DIGNITY IN MATERNAL HEALTH SERVICE DELIVERY

Cross sectional survey on factors that promote or compromise dignity in maternal health service delivery: Perspectives of Women and Midwives from Southern Malawi.

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Thesis submitted as a part of the
Master of Philosophy Degree in International Community Health
May 2011

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Funding, research sites, and supervision

Funding: This study was funded by Norwegian State Educational Loan Fund and NUFU in partial fullfilment for Master of Philosophy in International Community Health.

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Acknowledgement

As I look over the past years, I realized that no one succeeds in goal achievement without the support, encouragement and friendship of significant others. As such it will be unwise not to acknowledge the efforts of others in the development of this thesis.

Special regards to the Norwegian Government for offering me the scholarship to go through the Master program in International Community Health. Furthermore, the NUFU projects for contributing funds for my field work. My special thanks and appreciation goes to Prof. Johanne Sundby, Kenneth Maleta and Viva C. Thorsen for the guidance and supervision rendered throughout the various stages of proposal development and writing of this thesis.

Gratitude is also extended to the women who participated in the study, the midwives from QECH, Chiradzulu District Hospital and Milepa Health Centre. Mr Francis Masiye, for the assistance and efforts rendered during the data collection period. My sincere gratitude also go to the Department of General Practice and Community Medicine of the University of Oslo in Norway, the Malawi National Health Sciences Research Committee, Queen Elizabeth Central Hospital, Chiradzulu District Hospital, Milepa Health Centre, Namadzi Health Centre, St Joseph Mission Hospital and Zomba Central Hospital.

I would like to extend special thanks, gratefulness and appreciation to the following people whose diverse efforts helped to bring this thesis to reality: Thokozani Bema, Carol Kajawo, Jane and Harold Dzoole, Thocco Njoloma, Priscilla Bazale, Tiyaone Hendry, Elizabeth Mpunga, Mr S. Mbiriyawanda, Mr E. Sambani, Mr L. Banda, Aunex Kwekwesa, Chifundo Mambulu, Loney Mkwepere, Jacqueline Nkhoma, Ibrahim Mdala, Belinda Gombachika, Lillian Chirwa and Lucy Kululanga.

To Patnice, I cannot imagine how my life could have been in Norway without your support. You were everything: my guardian, my guider, my dearest, may the Almighty reward you accordingly.

I would also like to express my profound gratitude and appreciation to all those who in one way or the other contributed or supported this project through visible or invisible ways. To my mum, brothers, the Chigwenembes', the Wittikas', the Rashids' and the Njalas', I express my gratefulness and gratitude for your support during my study period.

Dedication

To my Heavenly father, ever faithful and powerful, would like to thank you for all the gifts rendered to me, and for taking good care of me during the two years. Without your unconditional love, this thesis would not have been the way it is now.

My refuge is the promise made to me through my birth verse, 1 John 5:15 NIV "And if we know that He hears us—whatever we ask—we know that we have what we asked of Him." The will of God will never take you to where the grace of God will not protect you.

I dedicate my work to you.

A note to the leaders:

The writing is intended to health care managers who are committed and interested in improving the provision of dignified care. Hence the writing has emphasized on areas where dignified care was not provided.

Abstract

DIGNITY IN MATERNAL HEALTH SERVICE DELIVERY

Cross sectional survey on factors that promote or compromise dignity in maternal health service delivery: Perspectives of Women and Midwives from Southern Malawi.

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Background and Objective

The concept of dignity is broad and complex as its interpretation is based on culture and social norms of a particular setting. According to the United Nations General Assembly and the World Health Organization (WHO), human dignity is the understanding of human rights and the foundation for patients' rights. A number of international instruments have been developed to promote patients' rights and dignity. Such instruments include the Universal Declaration on Human rights and the WHO statement on patients' rights. At country level, various countries including Malawi have developed their own instruments and strategies in line with the Universal Declaration and the WHO statement on patient's rights. However, despite development of such instruments and strategies, implementation of dignified care is impeded by a combination of challenges, for example, crowded health facilities. The purpose of this study therefore, was to explore factors that promote or compromise dignity in maternal health service delivery during labor and delivery in Malawi.

Methodology

A cross sectional survey that employed quantitative and qualitative data collection method was conducted at Queen Elizabeth Central Hospital in Blantyre, Chiradzulu District Hospital and Milepa Health Center in Chiradzulu, Malawi from August to December 2010. One hundred and twenty-six postnatal mothers and seventeen midwives working in the labor wards were the respondents to the survey questionnaire. Simple random sampling was used to draw the study participants. Quantitative data was analyzed using descriptive statistics and qualitative data was analyzed using content analysis.

Results

Major issues revealed by the study that influenced dignity in the study sites were: the physical environment, midwives and patients attitudes and behaviors, and care processes. Six out of 17 midwives expressed that the size and design of the infrastructure affect the dignity of their patients. As such 32% of the postnatal mothers' privacy was not maintained and 33% did not deliver in a clean labor room. Fifty two percent of the postnatal mothers and eight out of

seventeen midwives blamed the midwives attitudes and behavior as the reason why women are not treated with dignity. Seventy seven percent of the postnatal mothers and eight out of seventeen midwives felt that the patients' attitudes and behavior were responsible for the undignified care that women receive. The majority of the women (62%) expressed the need to be welcomed warmly, respectfully and quickly. Fifty one percent of the postnatal mothers were not given directions or escorted to the labor ward. Thirteen percent of the mothers were treated with less courtesy and respect and 88% were not involved in decision making.

Conclusion

This study has provided a tunnel through which the enablers and the barriers to the provision of dignified care can be viewed in Malawi. The understanding of the influencing factors of dignity will assist to develop strategies that will enable the health system to promote the positive influencing factors and eliminate the factors that compromise dignity, consequently improving the quality of maternal health care.

Keywords: dignity, attitudes and behavior, processes, warm welcome, Malawi

Abbreviations

ANC = Antenatal care

CHAM = Christian Health Association of Malawi

DHS = Demographic Health Survey

FGDs = Focus Group Discussions

ICN = International Council for Nurses

MDGs = Millennium Development Goals

MOH = Ministry of Health

NHSRC = National Health Sciences Research Committee

NMC = Nurses & Midwifery Council

NMCM = Nurses and Midwives Council of Malawi

NMTs = Nurse Midwife Technician

NUFU = The Norwegian Program for Development, Research and Higher Education

QECH = Queen Elizabeth Central Hospital

SPSS = Software Package for Social Sciences

SRNMs = State Registered Nurse Midwives

TA = Traditional Authority

UK = United Kingdom

WHO = World Health Organization

CHAPTER ONE: Introduction

This thesis uncovers some factors that influence dignity in maternal health service delivery in Malawi. The thesis has been organized in three main chapters. Chapter one is the introductory chapter, presenting the study background, a review of relevant literature and the research purpose. Chapter two is the methods chapter, presenting the description of material, participants and data analysis procedure. Chapter three is the results and discussion chapter, presenting findings and discussion, study limitations and study conclusions.

Background

Human dignity is the understanding of human rights and the foundation for patients' rights as asserted by the United Nations General Assembly[1] and the World Health Organization (WHO)[2]. Patients' dignity entails that patients should receive medical interventions and treatment that are consistent with the dignity and respect they are owed as human beings. This among others means providing, at minimum, equitable access to quality medical care, ensuring patients' privacy and the confidentiality of their medical information, informing patients and obtaining their consent before employing a medical intervention, and providing a safe clinical environment. However, patients' rights may vary depending on culture and social norms in different countries and jurisdiction (1).

The concept of dignity is broad and complex as its interpretation is based on culture and social norms of a particular setting. As such it is difficult to have a universal definition as various communities and groups brings a diversity of world and religious views, cultural understanding that inform and shape the use of the concept (2). For instance Jacobson, describes dignity as having two main meanings, human dignity and social dignity (3). She defined human dignity as "inherent and inalienable value that belongs to every human being simply by virtue of being human. It is held by species, collectives and individuals and it cannot be measured or weighed or destroyed, it is not contingent, conditional, contextual or comparative. Social dignity, is grounded in human dignity and is one consequence of its

[1] United Nations General Assembly in 1948, adopted the Universal Declaration of Human Rights which states that "recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice, and peace in the world"

[2] WHO states that: The Universal Declaration of Human Rights has been instrumental in enshrining the notion of human dignity in international law, providing a legal and moral grounding for improved standards of care on the basis of our basic responsibilities towards each other as members of the "human family", and giving important guidance on critical social, legal and ethical issues

recognition. It enacts the notion of universal value in behavior, perception, expectation. It is contextual, contingent and comparative, experienced, bestowed, earned through social interaction unlike human dignity" (3). "In health, human dignity may be used when advocating for right to health while social dignity may be used in surveys that use dignity as an indicator for system or provider responsiveness or models of dignity oriented care and professional practice. Human dignity is concerned with the ways in which dignity is either maintained or threatened through social interaction in specific health related situations" (3).

Within the context of maternal health, dignity is an important aspect during the entire period, from pregnancy to post pregnancy state. The labor and delivery period is crucial because potentially woman having a baby may lose her sense of dignity (4). "There are many circumstances during labor and childbirth where staff can fail to treat women with the respect and dignity they have the right to expect. These include the maintenance of her privacy and dignity during physical examinations, late-stage labor and childbirth" (5).

A number of international instruments have been developed to promote patients' rights and dignity. Such instruments include the Universal Declaration of Human Rights which states that "recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice, and peace in the world" (6). The WHO statement on patient's rights states that "patients must receive treatment consistent with the dignity and respect they are owed as human beings. This means providing, at minimum, equitable access to quality medical care, ensuring patients' privacy and the confidentiality of their medical information, informing patients and obtaining their consent before employing a medical intervention, and providing a safe clinical environment" (1). Furthermore Strategies have been developed to improve provider and system responsiveness, like the attainment of the Millennium Development Goal (MDG) number 5, target 5A, 5.2 proportion of births attended by skilled health personnel (7). At country level, various countries including Malawi have developed their own instruments and strategies in line with the Universal Declaration and the WHO statement on patient's rights. However, despite development of such instruments and strategies, implementation of dignified care is impeded by a combination of challenges, for example, crowded health facilities (8).

With reference to the Universal Declaration and WHO statement on patient's rights, dignity appears to be a right and a duty in both professional codes of conduct and human rights frameworks. Health workers are accountable for promoting the dignity of patients and clients (9). In care situations, according to Gallagher et.al, dignity may be promoted or diminished by: place (the physical environment), people (attitudes and behavior of the nursing team and others) and processes (the way care activities are carried out, routine and protocols) (10-12). In this study, the framework of place, people and processes was utilized to identify the factors that influence dignity during labor and delivery.

Literature Review

A review of literature was done prior to undertaking the study, during and after field work. The literature review is presented in the following subheadings; "dignity and place", "dignity and people", and "dignity and processes".

Dignity and Place

WHO states that the provision of a safe clinical environment is one way of maintaining people's dignity and respect (1;13). Physical environment has a potential of making consumers of care feel worthy or worthless, valued or devalued (9). In her definition of nursing Florence Nightingale also showed the contribution of the environment in the caring process. She said that nursing is putting an individual in a conducive environment for nature to take charge (14).

Studies have indicated that physical comfort, privacy and confidentiality influence dignified care with regard to dignity and place (5;10;15;16).

For example a small pilot study which was conducted in the United Kingdom (UK) on "Dignity in care: the views of patients and relatives" exploring dignity in health care and the circumstances which may have effect on it, found that sharing a bay with other patients can affect a patient dignity, expressed on the challenges of demarcating a bed with curtains, expressed on the potential ability of a mixed sex ward in diminishing dignity and the relatives also valued a pleasant environment and saw it as a means of promoting dignity (15).

In a study done in India on applying a framework for assessing the quality of maternal health services in urban India, whose main findings provide evidence that quality was far from optimal in both public and private facilities. The following problems were also identified as part of the main findings; lack of essential drugs, women being left unsupported, evidence of

physical and verbal abuse, and births occurring in hospitals without a health professional in attendance. From the narrative and the discussion in the study, it was expressed that women's' dignity was compromised by laboring in public areas and being examined in crowded places (5).

In another study conducted in the UK, on "Patients' expectations of the maintenance of their dignity" exploring patients' views regarding the factors that contribute to the maintenance of their dignity while in hospital, together with their perceptions of whether or not these were realized, indicates that privacy, confidentiality, communication and the need for information, choice, control and involvement in care, respect and decency and forms of address influenced dignity (16).

A dignity survey conducted in Uk on "Nurses views on dignity in care", aiming at gaining the perspectives of nurses, healthcare assistants and nursing students regarding the maintenance and promotion of dignity in everyday practice, showed that the respondents perceived that the physical environment and organization influenced the provision of dignified care. Respondents described how they managed to promote dignity during care activities which might threaten dignity through thoughtful planning, sensitive communication, preserving privacy and promoting choice. The study concluded that: a conducive physical care environment, a supportive organization and individual nurses' actions can do much to promote the dignity of patients while they are undergoing health care (10).

Dignity and People

In WHO statement on patient's rights, the healthcare team has a major role in maintaining the consumers' and colleagues' dignity and respect (1). Healthcare team members have a potential to humiliate, degrade and devalue but also to be devalued, degraded and humiliated (9). With regard to people, some of the documented factors that may influence dignity include: care that respect ones culture, involved in decision making, and patient-provider relationship that promotes open communication and empathy (5;10;17-21).

In a systematic review of "Pain and women's satisfaction with the experience of childbirth", Hodnet concluded that the influence of caregivers' attitudes and behaviors were powerful than the influence of pain, pain relief and intrapartum medical interventions on satisfaction with care (17).

In a study conducted in India whose aim was to assess the quality of care of institutional maternity services in an urban slum in India, women complained of being left unsupported for longer periods of time, being shouted at or slapped (5).

In an exploratory study done in rural Malawi on the factors that influence women's choice of place of delivery, Seljeskog et.al indicated that attitudes of midwives deter women from using maternal health services (20).

In a study conducted in United States, "Childbearing Women's Perceptions of Nursing Care That Promotes Dignity", aiming at gaining an understanding of perceptions of childbearing women about the maintenance of dignity while laboring and giving birth found that; midwives are pivotal in preserving dignity during childbirth, women appreciated feeling valued and respected and dignity was enhanced by nursing care that gave women their preferred level of control (18).

Dignity and Processes

Standardized protocols and routines are usually written with the intent to promote dignity but the manner in which they are implemented may promote or compromise dignity (9;10). Often standard protocols have technical, but no contextual or communication prescriptions. Thus, processes may have good technical content but potentially compromise dignity (9;10).

In respect to processes, studies show that women value their participation in decision making and explanations on the services they receive. Without active participation, they feel that technical care is intimidating and that some of the procedures are unnecessary (5;18;22-24).

In a study conducted among Lebanese women's in different areas in Lebanon to explore "Women's experiences of maternity care: satisfaction or passivity" showed that "women accord total trust to their physicians, and very rarely question the usefulness of many routinely applied procedures, even those which the literature shows are unnecessary. When probed, women reported that many aspects of the technical care are intimidating and that they experience discomfort with these procedures. The study expressed that women are more vocal about patient-provider communication and value good interaction with their provider. The extent of passivity and feelings of discontent women have varies according to their social class and the amount of psychosocial support they receive throughout the process of childbirth" (22).

In a study conducted in India whose aim was to assess the quality of care of institutional maternity services in an urban slum in India, women expressed that "they experienced unnecessary procedures and a number were unhappy at having to undergo those procedures. They were examined in crowded places, where curtains or blinds were not used regularly to shield women being examined" (5).

Previous studies

During the literature review, it was observed that patient dignity is of universal interest. Studies have shown that dignity is a fundamental human need, whether one is well or sick.

The review of literature has shown that on a global scale research on patient dignity is not new. There was a consistent call for more research into the topic, and a need for research from different methodological approaches. Previous studies conducted in this field were in relation to: elderly patients, medical and surgical patients, palliative care, patients in rehabilitative care settings, and child-bearing women (4).

With respect to the search results during literature review, research on dignity is limited in Africa, even though the topic has demonstrated global interest and that dignity is a fundamental human need. In Malawi there has never been a study that has explored the factors that influence dignity during childbirth (labor and delivery).

Previous research globally indicates unsatisfactory understanding about the subject conceptual framework, including definition relating to dignity, though patients and health professionals attach great importance to the concept. Although previous research have utilized different methodologies, more research with varied methods is still indicated (4).

A number of studies conducted in Malawi on Provider and system responsiveness indicates that; health seeking behavior is low as evidenced by some conditions highlighted in the Malawi DHS (25). Within maternal service delivery, skilled attendant at birth as of 2006 was at 53.6% and 91.8% antenatal coverage (26). In a baseline survey on early child development conducted in 2003, all women who did not attend antenatal clinics stated that they were afraid of the bad attitude of midwives (27). In Malawi restoration of dignity in care is an issue addressed by human rights based approaches (27). However, there has never been a study that

has looked at the factors that promote or compromise dignity in maternal health service delivery in Malawi.

Purpose of the study

The purpose of this study was to explore factors that promote or compromise dignity in maternal health service delivery during labor and delivery. This study will provide the mirror through which the enablers and the barriers to the provision of dignified care can be viewed and will provide the basis for future research. The understanding of the influencing factors of dignity will assist to develop strategies that will enable the health system to promote the positive influencing factors and eliminate the factors that compromise dignity, consequently improving the quality of maternal health care, thereby reducing maternal morbidity and mortality.

Research question

What are the factors that influence dignity in maternal health service delivery in Malawi?

Objectives of the study

Broad Objective:

The main objective was to determine from postnatal women and midwives the factors that enhance or compromise dignity during labor and delivery.

Specific Objectives:

1. To investigate the perspective of women and midwives on factors that influence dignity in relation to the physical environment of a health facility;
2. To identify the behaviors and attitudes that influence dignity in care from women and midwives perspective;
3. To identify care processes that influence dignity from women and midwives point of view.

Study area\ setting

The study was conducted in southern Malawi at Queen Elizabeth Central Hospital (QECH) in Blantyre, Chiradzulu District Hospital and Milepa Health Centre in Chiradzulu district. These facilities offer various services for general and obstetric patients.

Malawi

Malawi is a country south of the equator in sub-Saharan Africa. It shares boundary to the north and northeast with the United Republic of Tanzania; to the east, south, and southwest with the People's Republic of Mozambique; and to the west and northwest with the Republic of Zambia (25).

The country is divided into three regions: the Northern, Central, and Southern Regions. There are twenty eight districts in the country. Six districts are in the Northern Region, nine are in the Central Region, and thirteen are in the Southern Region. Administratively, the districts are subdivided into traditional authorities (TAs), presided over by chiefs. Each TA is composed of villages, which are the smallest administrative units and are presided over by village headmen (25).

As of July 2010, the population in Malawi was almost 15.2 million. According to Malawi census report of 2008, 45% of the population lived in the Southern Region, 42% lived in the Central Region and 13% lived in the Northern Region (28).

Malawi is classified as a low-income country and ranks amongst the poorest in Africa. The United Nations Development Programme (UNDP) report of 2010, indicated that 73.9% of the population live under $1.25 per day (29). The Southern Region has the largest poverty rate (60%) which means that three out of five people live in poverty.

The overall adult literacy rate in the country is 74.5% and the mean schooling years for adults is 4.3 years (29).

According to UNDP report of 2010 and UNICEF statistics of 2009, the country's total fertility rate is 6 children, the life expectancy at birth is 54. 6 years, the under-five mortality rate 100 per 1000 live births, the reported maternal mortality ratio 810 per 100,000 live births and the adjusted maternal mortality ratio of 510 per 100,000 live births. Looking at the health indicators with an equity eye, skilled attendant at birth for the poorest 20% is 43% and 77% for the richest 20%. The skilled attendant at birth for the country is 54% (29;30).

Ministry of Health (MOH) is responsible for health services in the country. The health delivery system consists of three levels: tertiary level (central hospitals), secondary level

(district hospitals) and primary level (health centers, maternity units, dispensaries) which are linked through a referral system. At the grassroots level community services are delivered by a net work of community-based units.

The health system in Malawi has inadequate numbers of health workers. The country struggles to keep pace with the demand for services; especially because of high population growth and high incidence of HIV/AIDS. In 2004, Malawi had 25.5 nurse midwives per 100,000 population (31).

Malawi mandated the Nurses and Midwives Council of Malawi (NMCM) to regulate Nursing and Midwifery education and practice. The Council has standards against which it measures the performance of the two professions. The standards are also utilized by the nursing and midwifery colleges to ensure that curricula are inclusive of its stipulations (32). The concept of dignity is taught during initial training of becoming a nurse or a midwife. It continues through in-service education after qualifying as a nurse or a midwife.

In Malawi, the patients' rights charter emerged following an advocacy training programme in 2000 (33). Nursing and midwifery curricula have incorporated the charter. Almost all the hospitals and health workers were sensitized on the charter. The integrated supervision checklist of the Malawi Ministry of Health checks the availability of the patients and providers' charter and a complaint system for communities (34;35).

Queen Elizabeth Central Hospital (QECH)

Queen Elizabeth Central Hospital is situated in the city of Blantyre. It is a teaching hospital, a national referral hospital, and a district hospital for Blantyre. The obstetric and gynecological unit offers specialized obstetric and gynecology services. The obstetric part is manned by obstetricians, general practitioners (medical doctors and clinical officers), State Registered Nurse Midwives (SRNMs) and Nurse Midwife Technicians (NMTs). From January to December 2009, it had 7468 deliveries and 4076 caesarian sections (36). As a central hospital, QECH does not have a defined catchment population. The number of permanent midwives in the labor ward varies from time to time due to availability of staff at the facility. For example during the time of the development of the study protocol (January to June 2010), QECH labor ward had 16 permanent midwives. During the data collection period, it had 13 midwives.

Chiradzulu District Hospital

Chiradzulu District Hospital is a 300 bedded hospital situated 28 kilometers from Queen Elizabeth Central Hospital. It is a referral hospital for the health centers in Chiradzulu district serving a population of 318,586. The immediate catchment population for the district hospital is 24,358. Comprehensive emergency obstetric care services[3] are offered at the facility and the section is manned by general practitioners, SRNMs and NMTs. There were 134 midwives in the whole district and 60 midwives at the district hospital in 2010. The number of permanent midwives in the seven bedded labor ward varies from time to time, from January to June 2010 there were 10 midwives, from October to December 2010, eight midwives. It had 3,026 deliveries and 558 caesarian sections from January to December 2010 (36).

Milepa Health Centre

Milepa Health Centre is located in Chiradzulu District. It is 19 kilometers from Chiradzulu District Hospital. It offers primary health care services to the surrounding population (catchment population of 15,601) for both general and maternity patients. The obstetric section offers ordinary maternity services; it was not a site for basic emergency obstetric care services in Chiradzulu district. The maternity section had three bedded labor ward and nine bedded postnatal ward. It was manned by three NMTs. It had 969 deliveries from January to December 2010 (36). The number of midwives also varies, but from January to December 2010 there were three midwives.

Site selection criteria

There was no any scientific basis for the choice of the sites. The sites were chosen based on closed links in terms of referral services and to capture views from the different levels of health care provision in Malawi. The chosen health centre refers their cases to the chosen

[3] WHO, UNICEF, and UNFPA jointly issued guidelines recommending that for every 500,000 people there should be four facilities offering basic and one facility offering comprehensive essential obstetric care. Basic emergency obstetric and newborn care, provided in health centres, large or small , includes the capabilities for: administration of antibiotics, oxytocics, and anticonvulsants; manual removal of the placenta; removal of retained products following miscarriage or abortion; assisted vaginal delivery, preferably with vacuum extractor and newborn care. Comprehensive emergency obstetric and newborn care, typically delivered in district hospitals, includes all basic functions above, plus Caesarean section, safe blood transfusion and care to sick and low birthweight newborns, including resuscitation.

district hospital only and the district hospital refers their cases to the chosen central hospital only. The search was limited to the southern region for the researchers' convenience.

Study Population

The target population to the study was postnatal mothers before being discharged and midwives working in the labor wards because the study wanted to explore factors that affect dignity during labor and delivery.

Inclusion criteria

- Postnatal mothers in stable condition (being able to participate, those not experiencing severe complications) and willing to participate in the study
- Midwives working in labor ward and willing to participate in the study.

Exclusion criteria

- Unwilling to participate in the study
- Postnatal mothers in unstable condition (those experiencing severe complications)
- Midwives working outside the labor ward.

CHAPTER TWO: Methods

This chapter discusses the methodology of the study, presenting description of study design, study sample, data collection and analysis procedure.

Study design

What are the factors that influence dignity in maternal health service delivery is the question that the researcher wanted to address. In order to answer this question, a cross-sectional survey was conducted among postnatal women and midwives from three sites in Southern Malawi.

Exploratory or descriptive studies are used when little is known about a problem in terms of its characteristics or possible causes (37). A Cross-sectional survey was preferred in this case to explore the factors that affect dignity.

The study was facility-based as postnatal mothers were interviewed before discharge from the hospital. The advantage of a cross-sectional survey is that all the information is collected at the same time and subjects are contacted once (38). The study looked at the exposure (the factors) and the outcome (whether it promotes or compromise dignity) at the same time. Cross sectional designs makes it possible to study exposure and outcome at the same time (38). They are easy to carry out and cheap, this makes it to be ideal to the researcher who was a student in terms of time and financial limitations (38). According to Rothman, cross-sectional surveys might be used to sample opinions, to measure prevalence or to assess the relation between prevalence and possible exposure (39). He said sometimes cross-sectional studies can be as informative as longitudinal studies. In this case, the study wanted to sample opinions and find out the possible exposures for dignity. The researcher sought views of postnatal mothers and midwives in line with documented information on dignity and information gained from the focus group discussions. The survey questionnaires had closed-ended questions (for quantitative approach) and open-ended questions (free text) (for qualitative approach) to get views of the postnatal mothers and midwives (40;41).

The disadvantage of cross-sectional surveys is that it provides a snapshot picture of the studied concept because the data is collected at one particular point in time. The following are additional disadvantages (37-39;42):

- With cross-sectional survey, one can have data on many variables but these usually increase chances of error because there is no diversity in the period of collection.
- The cross-sectional survey can be used to collect data on attitudes and behaviors but cannot measure change because it has been collected at a fixed time, once.
- The survey can collect data from a large number of subjects which can increase cost with more subjects.
- The survey can also collect data from dispersed subjects which can increase cost with each location.
- Cross-sectional survey answers questions on who, what, when, where but cannot establish cause and effect.
- Cross-sectional survey is good for exploratory research but it cannot control independent variable the way experimental designs can manipulate independent variables.
- Cross-sectional surveys generate hypotheses for future research but it is difficult to rule out opponent hypotheses which can partly be due to limitation in establishing cause and effect.
- The data collected from cross-sectional surveys are useful to many different researchers but it is static and time bound because it can be applicable to the period when the data was collected.

There was no previous study about dignity during labor and delivery in Malawi; as such a cross-sectional design was also suitable to establish base-line information.

The importance of utilizing both quantitative and qualitative methods to approach the study was that, the qualitative method assisted with getting an in-depth understanding of dignity since there was little information about dignity from the study site and country.

Sample size determination and selection

The sample size determination in this study was done using tables by Lwanga and Lemeshow. A confidence interval of 95% was used to increase the probability of getting true information. Nine percent was used as the total percentage points of the error that can be tolerated on each side of the figure obtained (absolute precision). This was done in consideration of time and resource constraints. The sample size was high if an absolute precision of 5% was used. To determine the sample size, a prevalence of 50% was used because it was not possible to estimate the prevalence of dignity for health facilities in Malawi. Lwanga and Lemeshow indicated that it is the "safest" choice to use 0.5 for prevalence because the required sample size is largest when p = 0.5 (43). The sample size was arrived through a calculation using the following parameters:

$n = Z^2_{1-\alpha/2} P (1 – P)/ d^2$

P = Prevalence = 50%

d = absolute precision = 9%

$Z^2_{1-\alpha/2}$ = confidence level = 95%

Sample = 119

One hundred and twenty-six participants, forty-two from each site, were recruited. With the three sites, the researcher decided to have equal number of participants. There was no scientific justification for having equal numbers. The plan was to have forty participants from each site making a total of one hundred and twenty participants instead of one hundred and nineteen. But during data collection, the researcher interviewed one hundred and twenty-six participants.

As the researcher wanted to find factors that influence dignity within maternal health services specifically labor and deliver, the sample was drawn from the users of labor and delivery service. They were drawn through simple random sampling. Women with an odd admission numbers were sampled to be asked for interviews. The odd admission numbers were arrived at by a toss of a coin on whether to have even or odd numbers. This was done in order not to include everyone who delivered on that particular interview day. This sampling method was not applicable to the midwives because the number of midwives working in the labor wards was already low, QECH labor ward had thirteen midwives, Chiradzulu District Hospital

labor ward had eight, and Milepa health centre labor ward had three. All the midwives who were not on holiday during the data collection period were asked to participate in the study. Out of the twenty four midwives from the three sites, seventeen consented to being interviewed (nine from QECH, five from Chiradzulu and three from Milepa). The seven midwives who were not interviewed, four were on holiday (one on sick leave, one on maternity leave and two on annual leave), three were unwilling to participate.

Data collection procedure

Preparation for data collection

a) Securing ethical clearance

Before commencing the study, the research project was approved by the section of International Community Health, at the Department of General Practice and Community Medicine, Faculty of Medicine of the University of Oslo. Ethical clearance was sought both in Norway and in Malawi. In Malawi the study was approved by the National Health Sciences Research Committee (NHSRC). Permission to use the study sites was sought from QECH and Chiradzulu District Health office for Chiradzulu District Hospital and Milepa Health Centre.

Written consent from participants was obtained before each individual interview session. Participation in the study was voluntary. Information was given to them (ref appendix 1) after which they were making their own informed decision to participate. No names were written on the questionnaires.

b) Recruitment and training of focus group discussion research assistant

Compliance officer and honorary lecturer of bioethics at the University of Malawi, College of Medicine was recruited to assist with focus group discussion facilitation. He was recommended by the Malawi based supervisor, as he was also assisting much with qualitative studies of the College of Medicine. He is experienced in conducting and teaching qualitative studies.

The research assistant was approached a month before conducting the focus group discussions and he was given the study proposal to go through before engaging in discussion. The researcher ensured that proper information was given to the research assistant about the study,

the content, purpose and ethical principals. Three meetings were held between the researcher and the assistant before conducting the focus group discussions (FGDs).

c) Focus Group Discussions.

Because the researcher had a limited working knowledge of dignity in the specified study sites', it was decided that before the data collection process, the first thing was to talk with key informants; safe motherhood task force members, chiefs and elderly men, elderly women, women of child bearing age, about dignity. Thus eight FGD's were conducted with women and men separately (four from catchment area around Chiradzulu District Hospital and four from Milepa catchment area). The focus groups had a minimum of 6 members and a maximum of 8 members. The FGDs were conducted in Chichewa. The research assistant facilitated seven discussions and the researcher one discussion. The FGDs provided an understanding of the community's views of dignity, their expectations with regards to dignified care and their experiences of being treated with or without dignity by the midwives at the health facilities, as WHO, Caulfield and Chapman indicated that the understanding of the concept of dignity is shaped by cultural and social norms (1;2). The information and knowledge gained from the FGDs assisted to review the questionnaires that were to be used for data collection. Questions nine, ten, twenty-four, thirty-five, fifty-one, and sixty-two were added on the postnatal mothers' questionnaire (see appendix 2). The modified questionnaires were later pre-tested before the actual data collection.

d) Piloting of the questionnaire.

The pilot study to test the questionnaires was done at Namadzi Health Centre (in Chiradzulu district), St Joseph Mission Hospital (at Nguludi, in Chiradzulu district) and Zomba Central Hospital in Zomba, Malawi. Zomba shares boundary with Chiradzulu and Blantyre. Pilot testing in both cases was done with participants having similar characteristics as those that participated in the main study. The pilot testing was done in sites that were not participating in the main study. Ten percent of the study sample size was the proportion that was used for the pilot sample size (44). Twelve postnatal mothers and five midwives were interviewed from Namadzi, Nguludi and Zomba instead of only three midwives. The intent was to interview one midwife from each site but it was felt that two midwives can give a clear picture.

Unfortunately midwives from Zomba Central Hospital were busy so only one midwife was interviewed.

The pilot study enabled the researcher to revise the tool by checking for the duration as well as the meaning of the questions to the interviewees, the sequence of the questions if logical, if the wording of the questions were clear, if translation was accurate, if there was sufficient space for the answers, if there was a need to change closed questions to open ended questions, if there was a need to adjust the coding system and if there was a need for additional instructions. The modifications were made accordingly. Major modifications were on question 26, which had six (a to f) parameters, with the pretesting, some were dropped and remained with three (a to c) (see appendix 2).

Data collection

Approach used

Two questionnaires, one for the women and the other for the midwives, were used to collect data in all the three sites (see appendices 2 & 3). They covered similar issues dealing with "dignity and place", "dignity and people", and "dignity and processes" but were phrased differently to suite the postnatal mothers and the midwives perspectives. The questionnaires were prepared in English. The one for the postnatal mothers was translated into Chichewa, the official local language for communication in Malawi. The interviews were conducted in Chichewa by the researcher.

The researcher was given a secure, private room for the interviews at the three sites. Interviews were conducted after every three days per site. This was done because three sites were planned for data collection so on every third day the researcher had to go to a site. Data were collected using a hard copy of the questionnaire and was entered into the computer using SPSS software package version 18. On average each interview last for twenty to thirty minutes. At the end of each interview the questionnaires were checked for completeness before concluding the interview session. At the end of each day, all data entered into the computer were cross-checked to ensure correct entries.

Data handling

The collected data were checked at the end of each interview and cross-checked when entering into SPSS and at the end of the day. A final cross-checking was done before cleaning the data for analysis. The rationale for checking and cross-checking was to see if all the needed information was collected as well as checking for accuracy and consistency. Each completed questionnaire that was entered into SPSS was assigned an ID (identity) number for reference. Questionnaires did not have an interview number and a date; there was no coding of a questionnaire against an individual. Interviews were conducted in a private room, where there was only the interviewer and the interviewee to maintain privacy and confidentiality.

Completeness of the questionnaires was also cross checked at the beginning of data processing for analysis. There was no questionnaire with incomplete or inconsistent information. Filled questionnaires were put in two groups; for postnatal mothers and midwives. It was further grouped per facility. Six boxes were used for data storage. Sorting was done daily upon arrival from the field. The questionnaires were handled by the researcher and were kept safely in a locked filling cabinet.

Data analysis

Upon finishing the data collection process and entering all the data into the computer, routine checking and data cleaning were performed.

The quantitative data was analyzed with the Software Package for Social Sciences (SPSS) version 18. Using the package, data cleaning was done using the edit, transform and data menu. The cleaning was done by counting values within cases, identifying duplicate and unusual cases, checking minimum and maximum values and outliers, and frequencies were also run. The analyze menu was used for analysis where descriptive statistics were run.

Content analysis was done for the brief responses from the open ended questions. This is an approach in analyzing and interpreting narrative data (41;45). The qualitative data was from the 120 postnatal mothers and 17 midwives who were interviewed using the structured questionnaire. As highlighted, the structured questionnaires had open ended questions where the views of the respondents were solicited.

The first step in content analysis was getting to know the data. The text were read and re-read and impressions were written down as the texts were read. Since the responses were brief, some of the responses needed to have follow- up questions or probes to get the meaning from the responses. So because there were no probes and follow up questions, this affect on quality of the data.

The second step was to focus on what to analyze. The purpose of the study was to find out factors that influence (promote or compromise) dignity. In finding the factors the study also aimed at understanding the participants understanding of the term dignity, their expectations when they go to seek care in the health facility and what they think are the reasons why some other women are not treated with dignity when they are at the hospital seeking care. This information was felt to assist the researcher in understanding the factors better. For the midwives, they were also asked on how they think of the physical environment where they work, and the organization/management. The focus was on the question so all responses from participants were put together per question to identify consistencies and differences. Then relationships and connections between questions were explored.

The third step was categorization of the information into different themes. Themes or coherent categories were identified (ideas, concepts, behaviors, interactions, incidents, terminology or phrases used). This was done to summarize and bring meaning to the text. Some of the categories were already preset with reference to used literature. The information from the texts was searched to match the themes. Some themes emerged from the text, and from the respondents' information. Differentiation and discrimination of the data was done by having subthemes from the main categories.

The fourth step was identification of connections and patterns within a question, theme or between the questions and themes. This was realized (noticed) when the data was being put in themes. Similarities and differences of the responses were captured within a question, theme. Key ideas on the questions were noted, a summary for each category was written. Larger categories, e.g. behavior, that constitute several categories were created. This was done to see how the parts related to the whole. The number of times a theme comes out was counted to come up with relative importance. But all responses were scrutinized for unique themes which were not apparent. All these were done to note a general pattern. Connections on how the themes were coming up were also looked at to assist with the explanations on why some other things were happening.

The last step was interpretation of the information. Themes and connections were used to explain the findings. Meaning and significance was attached to the analysis. A list of important points was made.

CHAPTER THREE: Results and Discussion

This chapter report on the research findings, a discussion of main findings in relation with the objectives and in comparison with literature, a discussion of methodological issues (study limitations), conclusion, recommendations and suggestions for future research.

Findings and discussion

Findings from the quantitative and qualitative sections are presented separately. Both data were collected using survey questionnaires: one for postnatal mothers and one for midwives. The instruments had both quantitative and semi-qualitative questions. A total of 126 postnatal mothers and 17 midwives were involved in this study. There were 42 postnatal mothers and 3 midwives from Milepa Health Centre; 42 postnatal mothers and 5 midwives from Chiradzulu District Hospital; and 42 postnatal mothers and 9 midwives from Q.E.C.H.

The socio demographic characteristics of the participants (both postnatal mothers and midwives) are presented first, followed by the quantitative findings, qualitative findings, contrasting the quantitative and qualitative findings, and lastly summary of the findings. The findings are presented with discussions and interpretations of their meaning.

Socio Demographic Characteristics

Table 1 summarizes the socio demographic characteristics of the participants.

Table 1: Demographic characteristics

Characteristics	**Postnatal Mothers n = 126**		**Midwives' n = 17**	
	Frequency	%	Frequency	%
Sex				
Male			3	18
Female	126	100	14	82
Age				
<15years	1	1		
15-49years	125	99	15	88
>50years			2	12
Ethnicity				
Chewa	22	17	1	6
Lomwe	60	48	7	41
Sena	4	3	1	6
Yao	21	17	3	18
Tumbuka	1	1		
Ngoni	11	9	5	29
Others	7	5		
Religion				
Christian	118	94	16	94
Moslem	7	1	1	6
Others	1	5		
Marital Status				
Single	2	2	2	12
Married	124	98	11	64
Widowed			2	12
Others			2	12
Number of children[4]				
0			4	23
1	34	27	5	29
2	27	21	3	18
3	20	16	3	18
4	18	14		
>4	27	21	2	12
Education				
Primary	98	78		
Secondary	26	21		
Tertiary	2	1	17	100
Local language				
Chichewa	124	98	17	100
Sena	1	1		
Other	1	1		
Occupation				
Working	9	7	17	100
Not working	117	93		

[4] The total percentage for the postnatal mothers is 99. One percent has been lost because of the decimals. Two values have same frequencies so it will be a bias to offer the 1% to one of them.

Almost all the respondents were within the age category of 15-49 years (99%). The majority were Lomwe by tribe (48%), Christians (94%), married (98%), and had at least a child (78%). They also had a primary level education (78%), were not employed outside home (93%) and spoke Chichewa (98%) as their local language. The majority of the women were financially dependent on their husbands, as they were not working. A higher percentage of these postnatal mothers' husbands were subsistence farmers who can be ranked in the low social class.

The majority of the midwives were females (14 out of 17). Most of them were within the age category 15-49years (15 out of 17), Lomwe by tribe (7 out of 17), Christians (16 out of 17), married (11 out of 17). The majority of the midwives (13 out of 17) had had an experience of going through labor and delivery because they had at least one child. They have lived experiences of how one feels and what one expects from the care provider when one is going through the process of labor and delivery, though they may not have delivered in a public facilities.

Quantitative findings and discussion

The quantitative section of the survey has three sections. Questions were related to "dignity and place", "dignity and people" and "dignity and processes".
The findings presented and discussed below are therefore based on the descriptive analysis that was outlined in the methods section. There was no comparison across the three facilities as the study aimed to gain a general picture of the factors that influence dignity.

Dignity and place

Both the postnatal mothers and the midwives were asked questions to assess whether the place promoted privacy and confidentiality, whether it enhanced communication and whether it was clean for the provision of labor and delivery care. This was in line with objective number one: ***"To investigate the perspective of women and midwives on factors that influence dignity in relation to the physical environment of a health facility."***

The postnatal mothers were asked nine questions with regards to dignity and place. They were asked if they labored and deliver in a private room where maximum privacy was provided.

For those who did not deliver in a private room, they were asked whether their beds were screened to maximize privacy. All were also asked if history taking and personal questions were asked in a private room where they can be free to talk more about themselves. They were asked if they were provided with functioning and clean bathroom, toilet and washing area. These questions were asked to determine if the women were regarded with the respect they owed as human beings. Having access to functioning and clean bathroom, toilet and washing area would illustrate a form of respect which in turn could preserve their dignity. They were asked if their labor and delivery room and bathroom were cleaned to determine whether they were provided with a safe clean environment. Table 2 shows the findings on these nine questions.

Table 2: Dignity and place

Parameters	Frequency	Percent
Labor room		
In a separate room	76	60
with other women	50	40
Total	126	100
Bed screened		
Screened	34	68
Not screened	10	20
Partly screened	6	12
Total	50	100
History taking		
Private room	124	98
In the presence of others	2	2
Total	126	100
Personal questions		
Private room	125	99
In the presence of others	1	1
Total	126	100
Bathroom[5]		
Functioning	75	59
Not functioning	1	1
Functioning but dirty	11	9
Did not visit the bathrooms	38	30
not in use because they have just finished moping	1	1
Total	126	100
Toilet		
Functioning	62	49
Not Functioning	1	1
Functioning but dirty	10	8
Did not visit the toilet	53	42
Total	126	100
Washing area[6]		
Functioning	31	24
Functioning but dirty	2	2
did not visit the washing area	59	47
There is no washing area	34	27
Total	126	100
Room cleaning[7]		
Zero	41	33
Once	41	33
Twice	22	17
Thrice	8	6
more than three times	1	1
did not see them cleaning	13	10
Total	126	100
Bathroom cleaning[8]		
Zero	2	2
Once	12	9
Twice	10	8
Thrice	2	2
More than three times	1	1
did not see them cleaning	99	78
Total	126	100

[5] The total percentage was coming to 101 upon removing decimals. Functioning bathroom was 59.5 = 60%, but it has been kept at 59% to maintain total percentage of 100.

[6] The total percentage was coming to 101 upon removing decimals. Functioning washing area was 24.6= 25%, but kept at 24% to maintain total percentage of 100.

[7] The total percentage was coming to 101 upon removing decimals. Room cleaning twice was 17.5 = 18, but kept at 17% to maintain a total percentage of 100.

[8] The total percentage was coming to 102 upon removing decimals. Bathroom cleaning once was 9.5 = 10% and those who did not see the cleaners cleaning the bathroom were 78.6 = 79%. But has been kept at 9% and 78% to maintain 100 as a total percentage.

Privacy

According to the findings in the table above, the postnatal mothers had favorable responses in almost all the nine questions. They were treated with the expected respect and dignity with regards to place. However, for 32% (n=50) of the postnatal mothers' privacy was not maintained. Their labor and delivery beds were partly screened (12%) or not screened at all (20%). These women were exposed to other women and guardians, other health workers and students who were also in the labor ward. Studies that have looked at dignity and place also highlighted concerns about being exposed. For example, in a study conducted in India, women complained of being exposed, that they were examined and delivered in crowded places where curtains or blinds were not used regularly to shield women during the procedures (5). A study conducted by Matiti M.R. and Trorey G.M. expressed complaints about badly fitting curtains and transparent curtains (16). The women's need for privacy was not met. It cannot be the sole responsibility of the midwives but management also has to make arrangements that all the resources are available for the midwives to provide dignified care. In this case there was a need to have adequate screens for the midwives not to partly screen the beds or not to screen the bed at all.

Three percent of the postnatal mothers were not provided with a conducive environment for them to speak freely about personal issues. History taking for 2% of the postnatal mothers was done in the presence of other people and 1% was asked personal questions in front of other people. In Matiti and Trorey study, patients' expressed that discussion of matters pertaining to illness should be done in private, arrangement should be made to take patient to a private area for discussion (16). Some issues are sensitive and one cannot comfortably explain personal information in front of others for example; issues of abortions, stillbirths and HIV status. So these women were not treated with the expected dignity with regards to the place where they were asked the questions.

Admission area

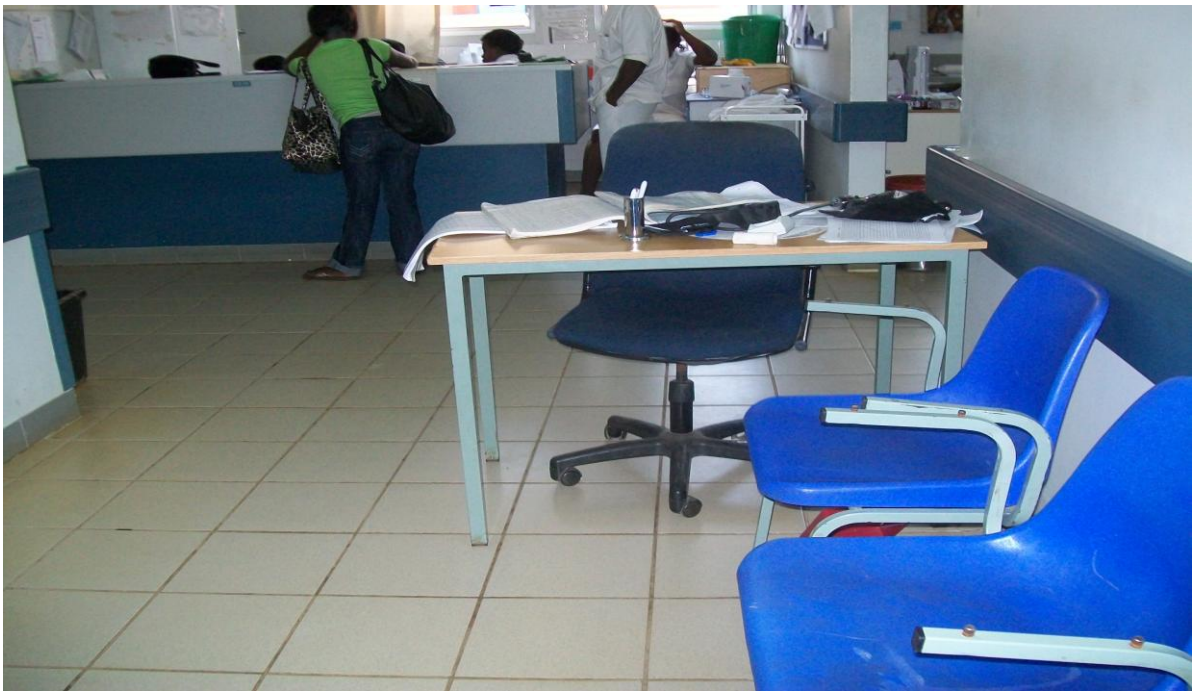
Figure 1 shows the admission area of one of the study site. The admission area was improvised in a corridor/passage going to the midwives' station. To preserve patients' dignity, it would have been better if they had improvised one of the rooms or one of the labor beds, or at least used a divider and placed a chair to the side of the table, or made a room back at the midwives' station.

Figure 1: admission area

In the above admission area when all the chairs are occupied, the one admitting the patients does not consider privacy and confidentiality of the patient information. She will just ask the questions in front of the other patients.

Figure 2 shows the distance from the admission area to the midwives' station. When the midwives are not busy in the labor ward, they are at the station, so when another midwife is admitting a patient the others can over hear what is being said. At times they even give unsolicited opinions over the conversation. In Matitis' study, patients accepted that sharing of their information between professionals was a necessary part of their care, but they were concerned about where this took place. If it happened at the midwives' desk, patients felt that their confidentiality may be infringed (16).

Figure 2: showing the distance from the admission area to the midwives' station



Cleanliness

Cleanliness was regarded as a sign of respect by patients in Veras' study (1993) as expressed by Hulton (5). In this study, the majority of the postnatal mothers used a clean delivery room, 33% did not deliver in a clean room and 10% were not provided with a functioning and clean bathroom. These women's dignity was violated. In Gallagher and Seedhouse study, the relatives of patients commented on the importance of their loved ones living in a clean and pleasant environment. One even said that *"that's why I try to make the room smell nice, bring flowers in, There's a nice ambience in the room. I feel very lucky, privileged in a way that she has her own room.*" (15). The cleaners also had a handover system whereby prior to ending their shift they have to mop the floors and clean toilets and bathrooms. After cleaning they lock bathrooms in order to hand them to the cleaner of the next shift while they are clean. So during the period when the cleaner is waiting for the next shift to start, the women are denied access to the toilets and bathrooms. The cleaners advise the women to use their basins until the next shift. The women did not have a say, they just use the basins, because in this situation, the workers were in control.

Washing area

In the three facilities where data were collected, washing of personal belongings was done by the patients themselves. Moreover, the mothers were not provided with hospital gowns because of infection control. Both postnatal mothers and midwives reported that there was a shortage of linen in the hospital; as such most of the times the majority of the women (75%) brought their own linen. The postnatal mothers (27%) also reported that there was no washing area in their facilities while 2% reported being provided with a dirty washing area. Some women used the bathrooms for washing. If they were caught, a cleaner would punish them by making them mop all the rooms in the bathing area.

The midwives

The midwives were asked about the physical environment as well. They were asked if there were areas where dignity is exercised or compromised. They were also asked to suggest what need to change to help them maintain, promote and deliver dignified care in a more effective way.

The midwives' responses indicated that they had inadequate screens and hospital maintenance was not adequately done. They had no electricity or generators in times of black outs. Six out of the seventeen midwives felt that the environment was conducive for the provision of dignified care because in the labor ward there were policies, screens, curtains and the labor ward was partitioned in such a way that the women were not able to see each other. However the majority (11 out of 17) thought that it was not conducive, but acknowledged that if there was only one patient in labor ward then it can be possible to offer dignified care. They thought that even though the labor wards had cubicles, screens and curtains, one can still easily hear what the others are saying. The majority of the midwives (14 out of 17) recommended that individual rooms should be considered in order for them to provide dignified care. They also said that other women are not treated with dignity because the facilities have inadequate space and few beds. So the wards are usually full and other women are given floor beds.

The responses from the midwives may partly explain the findings from the postnatal mothers. The inadequate screens may explain why women are partly screened or not screened at all.

The inadequate space would explain why history taking is done in the presence of others. Nonetheless measures have to be put in place to make sure that all the women are treated with the expected dignity.

Figure3[9]: delivery rooms of two of the study sites.

[9] The bed with a basin on it means it is an occupied bed. The basin is the one which the women are advised to use as a toilet during labor. Each woman is advised to bring a basin from home.

Dignity and people

WHO states that the healthcare team has a major role in maintaining the consumers' and colleagues' dignity and respect (1). The analysis on dignity and people is in line with objective number two: ***to identify the behaviors and attitudes that influence dignity in care from women and midwives perspective***.

The quantitative part looked at the way in which midwives and other health personnel in general interacted with the postnatal mothers. Questions were related to how the women felt about the treatment they received and their experience over the time of their stay at the health facility. They were asked about the interpersonal skills of the midwives. This included questions related to communication, listening and responding.

Table 3 presents the responses to the nineteen questions that were asked to determine if the women were treated with dignity with regards to midwives actions (attitudes and behavior).

Table 3: Dignity and people

	Frequency	Percent		Frequency	Percent
Point of entry escort			**Point of entry directed**		
Escorted	83	65.9	Directed	21	48.8
Not escorted	43	34.1	Not directed	22	51.2
Total	126	100.0	Total	43	100.0
Able to hear staff language			**Asked about needs and wellbeing**		
Yes all	125	99.2	Never	115	91.3
Yes, some health workers	1	.8	At times	5	4.0
Total	126	100.0	Always	6	4.8
			Total	126	100.0
Bed covered			**patient covered**		
Never	1	.8	Never	3	2.4
Always	125	99.2	Always	123	97.6
Total	126	100.0	Total	126	100.0
Exposed unnecessarily			**Communication tone**		
Never	122	99.2	Low tone	117	92.9
At times	1	.8	High tone	9	7.1
Total	123	100.0	Total	126	100.0
Shout communication			**Courtesy/respect**		
Shouting	8	6.3	Never	7	5.6
No	118	93.7	Sometimes	9	7.1
Total	126	100.0	Always	110	87.3
			Total	126	100.0
careful listening			**understood explanations**		
Never	10	7.9	Never	9	7.1
Sometimes	5	4.0	Sometimes	6	4.8
Always	111	88.1	Always	111	88.1
Total	126	100.0	Total	126	100.0
Provided assistance as soon as needed			**Shouted**		
			Yes	12	9.5
Never	5	4.0	No	114	90.5
Sometimes	4	3.2	Total	126	100.0
Always	65	51.6			
I never called for help	52	41.3			
Total	126	100.0			
Slapped			**Pinched**		
No	126	100.0	No	126	100.0
Asked to clean delivery bed			**Asked to Wash hospital linen**		
Yes	19	15.1	Yes	1	.8
No	107	84.9	No	125	99.2
Total	126	100.0	Total	126	100.0
Asked to Mop					
Yes	2	1.6			
No	124	98.4			
Total	126	100.0			

With reference to the table above, the postnatal mothers' responses indicated that they were treated with dignity in various aspects, even though it was not for all of them.

Labor ward directions

Fifty one percent (n=43) of the postnatal mothers were not given directions or escorted to the labor ward. According to the assessment form for maternity unit entrances and main reception, the maternity entrances need to have understandable directions that can help one

arrive to the unit (46). They need to have an information desk with members of staff that are helpful over 24 hours. The staffs should be placed there to direct people to the unit (46).

Staff language

One postnatal mother was assisted with a white English speaking provider who had a translator to facilitate communication. The woman needs for communication in terms of appropriate language were met but there was a third party and possibly others were hearing the translation. Hulton expressed that women usually have questions that they hesitate to raise with a western health care provider, fearing that the question would be considered stupid (5). In this regard, it was not established if this woman felt the same. Lin and Tsai, commented that with regard to health or disease information, there is a need to communicate with patients in the language with which they are familiar (47).

Women needs and well being

To facilitate communication and provision of appropriate care, the postnatal mothers were asked about their needs and wellbeing. Matiti argued that in communication with patients, to neglect their needs is to fail to maintain dignity in care (48). Unfortunately the majority (91%) were never asked by the midwives how they were doing or if they needed anything during the course of their stay. In turn the midwives were assisting the women according solely to their assessment or what they considered good for the women. Some researchers suggested that if the midwife is informed about the patients' needs and wellbeing, the midwife has forethought of the patients' needs and expectations (10;48;49). Hence it is assumed that patients are given appropriate information and are rendered appropriate care. Kabakian-Khasholian et al expressed that women appreciated being asked about their problems. In their study, one woman indicated that she was feeling less pain when she was asked about her problems (22). Being reassured and shown that someone cared, assisted in allaying the woman pain.

Physical comfort

In this study, one woman was not provided with the necessary comfort as her labor bed was not covered. This woman experience what Kafulafula et.al indicated that in Malawi, it has even become part of the norm to nurse a laboring woman completely uncovered and without any linen on the bed (50). Providing physical comfort is one element of dignified care. Women appreciate when the midwives work towards achieving physical comfort of their

patients (18). In many studies women expressed that when their bodies are not exposed and physical comfort provided they felt dignified (10;16;18;49). Though the majority (98%) of the women in this study reported that they were not exposed, three women were exposed throughout the entire labor and delivery period.

Communication

Seven percent of the postnatal mothers indicated that the midwives were speaking loudly that others were able to hear their conversations. Six percent said that the midwives were shouting when communicating. Even though the shouting may have been directed at certain individuals, it showed disrespect to the women in general because at any given time still it could be them. Shouting at and belittling the patients in no way shape or form promote dignity. Baillie and Matiti suggested that the use of low tone by midwives is an expression of dignified care (10;16).

Courtesy and respect

Nicholson et al., Walsh and Kowanko, Mathews and Callister, highlighted that courtesy and respect are part of dignified care (18;49;51). Their studies indicated that women value being treated with courtesy and respect and that the women's' dignity is promoted if their individuality and personhood are acknowledged. Thirteen percent of the women in this study were treated with less courtesy and respect. They expressed that the midwives were not regarding them as human beings. To promote dignity, midwives must demonstrate and show courtesy and respect to the women.

Careful listening

Twelve percent of the postnatal mothers did not meet an attentive midwife during labor and delivery. The midwives sometimes or never listened to the women carefully. The women need the midwives to connect with them, to listen, and to show that they care. Clark indicates that maintaining dignity is not a science, but relies on understanding, and having empathy and compassion (52), which is manifested in the act of listening attentively and carefully.

Explanations

Twelve percent of the postnatal mothers were in contact with midwives who were explaining things in a way that they were not able to understand. Giving information and explanations

promote dignity. However the receiver of the message has to understand the contents of the message. Women do not value information that is given in a curt manner, or that is rushed (10;49). Midwives must seek confirmation that the patients understand what has been communicated or explained. Some patients felt that explanations were merely task oriented in Matiti study (16). They felt that other midwives give explanation because they have a duty to do so, the explanations were not given in a manner that conveyed that the midwives were happy with the task.

Assistance

Seven percent of the postnatal mothers were not given assistance as soon as they needed the help. As the scripture says, "treat someone as you would want to be treated yourself" is a sufficient explanation. The midwives needed to put themselves in the shoes of the laboring women. The majority (76%) of the women did not have guardians by the bed side. They relied on of the midwives, but the midwives were not there to give assistance as the women needed it for 7% of the postnatal mothers during labor and delivery.

Shouted

Ten percent of the mothers were shouted at and were belittled by the midwives during labor and delivery. This definitely did not make the women feel at ease because their dignity was violated. The interaction was neither professional nor therapeutic. The women were unable to answer anything else, because they did not really have expectations of compassionate care. Baillie pointed out that according to Nursing and Midwifery Council (NMC) (2004) and International Council of Nurses (ICN) (2001), midwives have a professional duty to respect patients' dignity (10).

Asked to clean, wash and mop

Fifteen percent of the postnatal mothers were asked to clean the delivery bed, one percent was asked to wash hospital linen, and two percent were asked to mop the floor. As expressed above, Clark indicated that maintaining dignity is not a science, but relies on understanding, having empathy and compassion (52). These women had just delivered, and were possibly still in pain and were weak, this should have compelled the midwives to be more considerate, empathetic and caring not demanding that they clean while in such a vulnerable state.

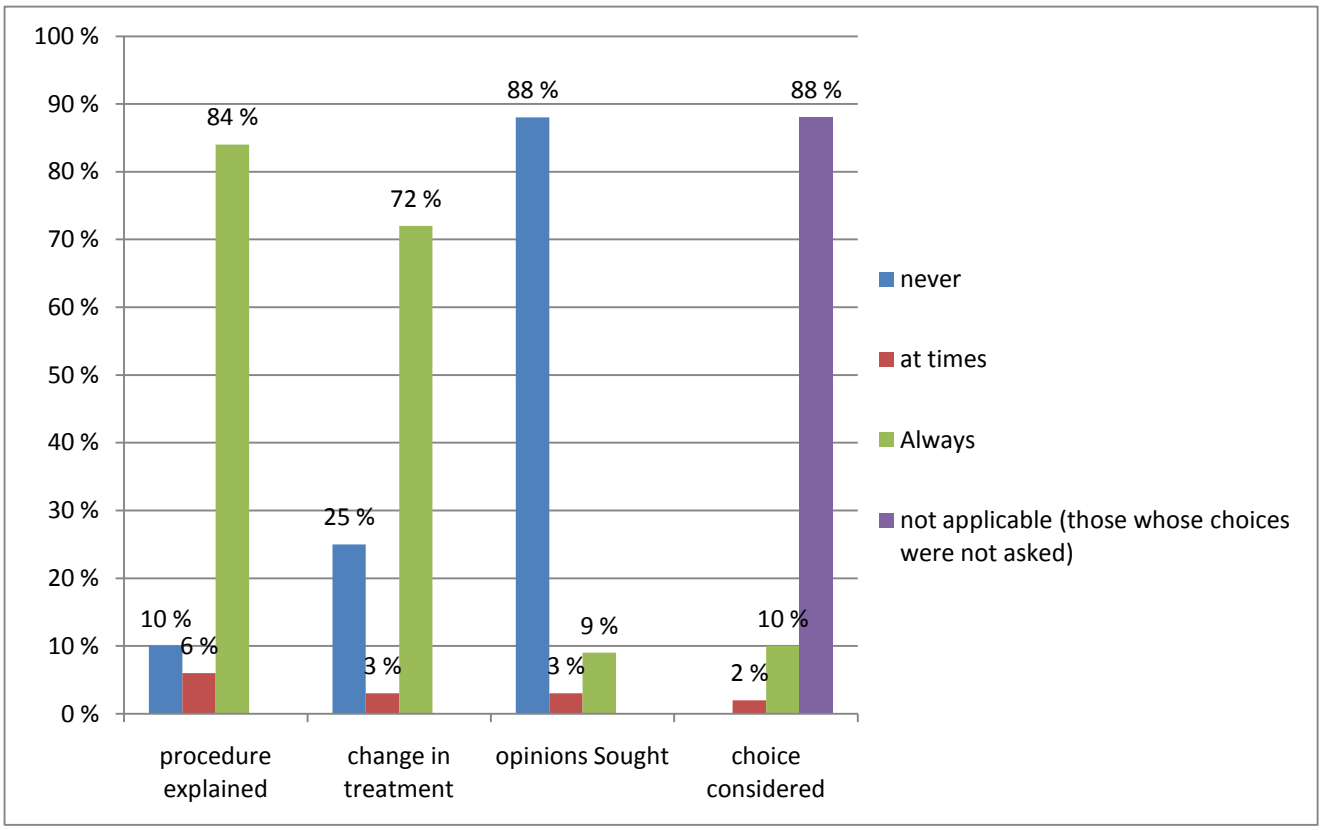
Dignity and processes

Processes in this study refer to the way care activities, routines and protocols are carried out. Standardized protocols and routines are usually written in a way to promote dignity but the way in which they are implemented can either promote or compromise dignity. Often standard protocols have technical, but not contextual or communication prescriptions. Thus, processes may have good technical content but compromise dignity.

Dignity and processes were analyzed in line with objective number three: ***To identify care processes that influence dignity from women and midwives point of view.***

The postnatal mothers were asked if midwives explained all procedures before carrying them out, if they were given treatment alternatives, if their opinions were sought and if their choices were taken into consideration. Figure 4 presents the responses from the postnatal mothers.

Figure 4: Dignity and processes



Unlike with "dignity and place" and "dignity and people" where the majority of the women were treated with the expected dignity, the majority were not treated with the expected dignity with regards to dignity and processes.

Explanations before carrying the procedure

The majority of the women (84%) said that the midwives were explaining all the procedures before carrying them out. However, from the women's' narrations, the explanations were not detailed; it was a matter of telling the women which procedure the midwife was going to do at that moment. The purpose of explaining before employing a procedure is for the woman to understand what is going to happen, the reason of doing the procedure, the consequences (benefits, harms) of the procedures and to get consent from the woman. Explanations and information are important for women to make decisions and give their go ahead, which makes them feel in control of their situation (53). From the women's narratives, the midwives used an authoritarian approach by being in control while the women were passive (53). Hulton stresses the importance of midwives' explanations that, whether or not a woman in labor clearly understands what is happening, why, and any specific instruction, it will determine her subsequent behavior (5).

Alternatives in care provision

As mentioned above the study also wanted to assess if the women were given alternatives so that they were able to choose care of their choice. Unfortunately the midwives are the ones who choose the care for their patients within the available alternatives, the patients are just informed. Matiti also indicates that the midwives determine what is best for their patients and they just inform them so that they can be aware of what is happening. In her study, patients expressed that they wanted an opportunity to make some choices about their care. They felt that; it was necessary to be given a clear, non-hurried explanation of alternatives and it was important to discuss patient care with the patient, not at the patient. Patients wanted to direct their own care when situations allowed (16). When patients make a choice out of the available alternatives, they feel that they are in control of the situation which in the long run preserves their dignity because the care is not directed by the midwives, but rather by their choices.

Seeking opinions

Only 12% of the postnatal mothers were asked about their opinions at a certain point during labor and delivery. The opinions or the choices were considered during the implementation of the processes, as indicated by one postnatal mother who said that she was in pain and she was offered to be given a pain killer which she declined because of misconception she had from friends that when one does not experience the pain she give birth to a dead baby, so she opted

to bear with the pain for a prayer. She said that the midwife was not upset and she assisted her nicely when she was delivering the baby.

The results indicated that although the midwives in Malawi are taught during their initial training to become a midwife or during in-service education to involve the patients, it is not being fully practiced (32). The women's views are not solicited or utilized most of the times as 88% of the postnatal mothers in this study were not asked about their views. The midwives have a professional obligation to recognize and value the role of the women as partners in and contributors to their care. Identifying patients' choices concerning their care and regarding the choices within the restrictions of professional practice, legislation and available resources is a step forward in promoting dignity of patients in care provision.

Midwives views

To identify the midwives' views on dignity and processes, the midwives were asked on the following issues:

1. To describe care activities that they undertook with their patients, that because of the type of the procedure or condition were mostly likely to lead to loss of dignity and what measures were taken to minimize the loss of dignity.

2. If nurse/midwives listen and respect women's choices and options regarding birth.

3. To rate the dignity of care they give to their patients

4. If they had enough time to devote to the dignity of their patients as part of their daily routine

5. If they ever felt upset or distressed because they were unable to give the kind of dignified care they knew they should.

6. If they knew any specific types of patients that were treated differently in terms of dignified care

Care activities

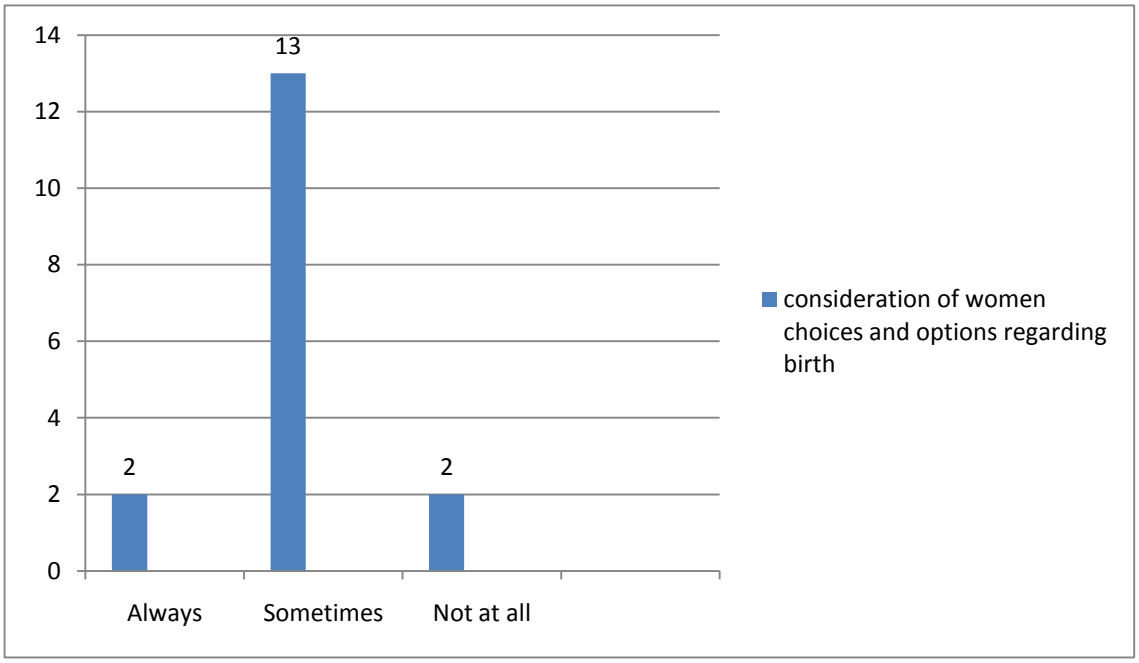
Fourteen out of seventeen midwives said that there was no care activity that most likely led to loss of dignity. However, three midwives felt that vacuum extraction, delivery and caesarian section that may be done against the women's will were most likely potential violators of dignity. It was felt that because during vacuum extraction there were always more than two

providers, the woman is exposed to more people than she might expect. Minimizing the number of providers by excusing the provider(s) after they have completed their service may resolve this problem. It was felt that during delivery a woman was exposed, hence the potential loss of dignity, and said there was nothing that was done to minimize this loss. It was felt that when a woman was taken for caesarian section which was against her will, lead to loss of dignity. The women sign consent forms even though they are not in agreement, to avoid wasting time of the midwife. In situations like these where they wanted to save the life of the baby and or of the mother it was difficult to minimize the loss. However, the majority felt that in all the procedures something could be done to minimize the loss hence they felt that there was no procedure that was most likely to lead to loss of dignity. Surprisingly no one mentioned admission process and breach of privacy which has been highlighted in the other areas. This can be attributed to the fact that the admission procedure is not taken as a technical procedure by the midwives. Baillie, Gallagher and Wainwright found that there was a wide range of care activities that could threaten dignity. Their study was not in a maternity setting, but procedures like admission, exposing procedures, invasive/technical procedures, intimate procedures/examination, communication, support with elimination or with hygiene and dressings can also be conducted in a maternity setting were mentioned (54).

Women's choices and options regarding birth

Figure 5 presents the midwives views on whether they listen and respect women's choices and options regarding birth.

Figure 5: Consideration of women choices and options regarding birth

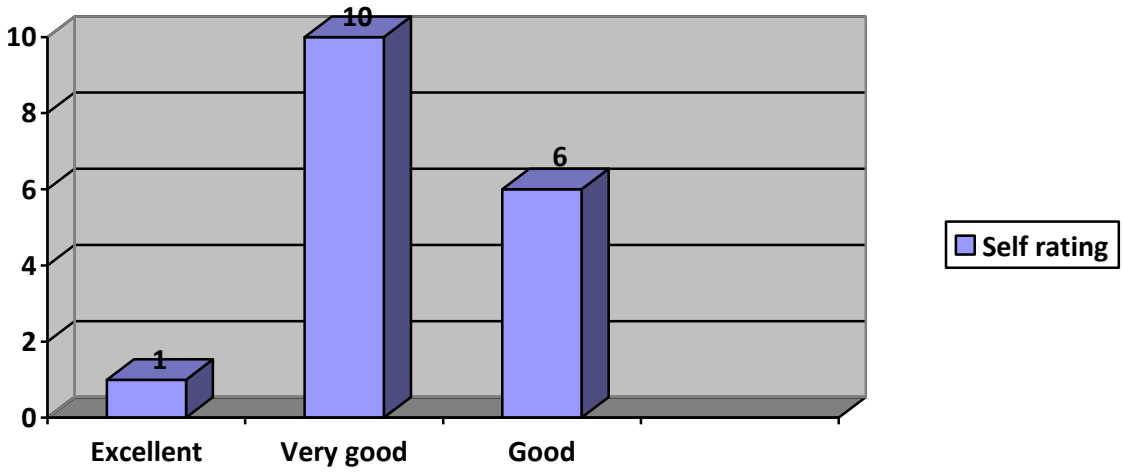


The results are in agreement with what the postnatal mothers expressed. The majority of the midwives (13 out of 17) felt that it depends with the issue. If it was life threatening the women's choices was not considered because it was a matter of saving a life. Two midwives said that women's views were not considered. Midwives did what they thought was best for the women. Nevertheless, two said that women's choices were always considered. This is in contrary with what women want as expressed in many studies (16;18;49;53;55). In Matiti study, patients expressed that there was lack of dignity when their preference were not considered and when there was a lack of understanding of the patient standpoint in the performance of intimate procedures (16).

Self rating on the dignity of care given to patients

However on midwives self rating on the dignity of care given to patients, the midwives were happy with the care they gave to their patients (figure 6). All of them rated themselves as being good, very good or excellent as opposed to neither good nor bad, bad or very bad. See figure 6:

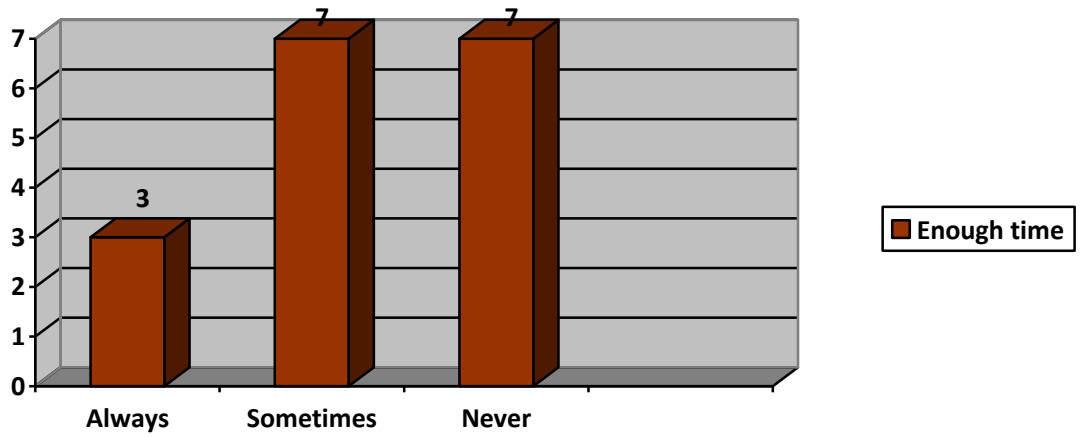
Figure 6: Midwives' self rating on the dignity of care given to patients



Enough time to deliver dignified care

Even though the midwives rated their provision of dignified care as being above average, the majority (14 out of 17) indicated that they did not have enough time to devote to their patients' dignity (figure 7).

Figure 7: Midwives' rating on having enough time to deliver dignified care

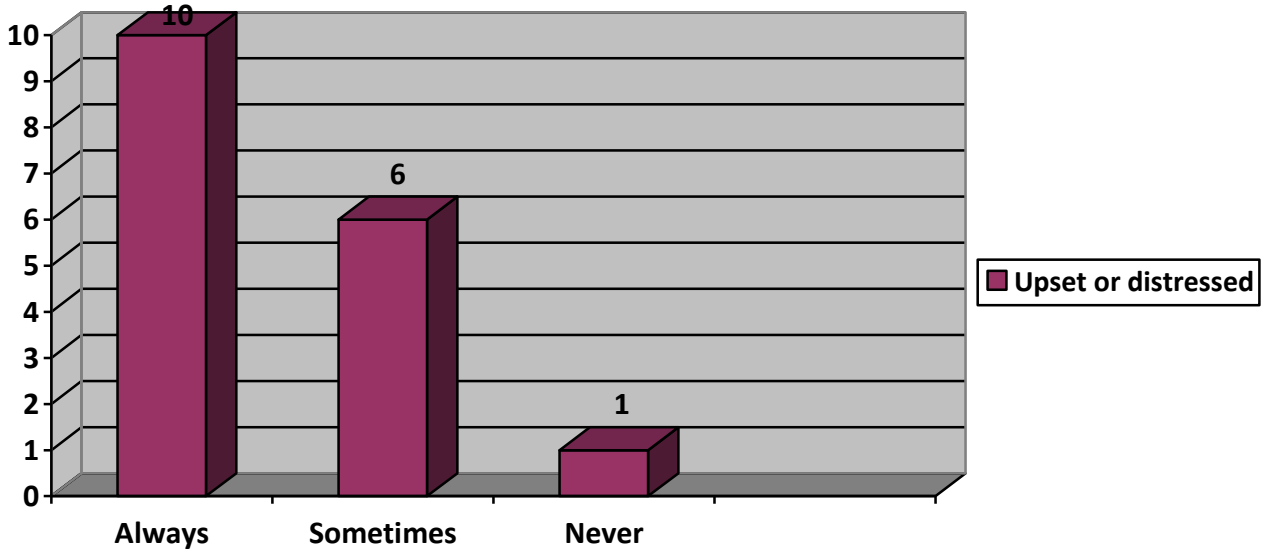


Reaction on the provision of undignified care

However on whether they ever felt upset or distressed because they were unable to give the kind of dignified care they knew they should, the midwives expressed that they became distressed when they did not treat the women with the expected dignity. Some were failing to sleep because they dreamt about their patients' dignity being compromised. One felt

unbothered by treating patients without dignity because the practice became part of routine care. She was never upset or distressed.

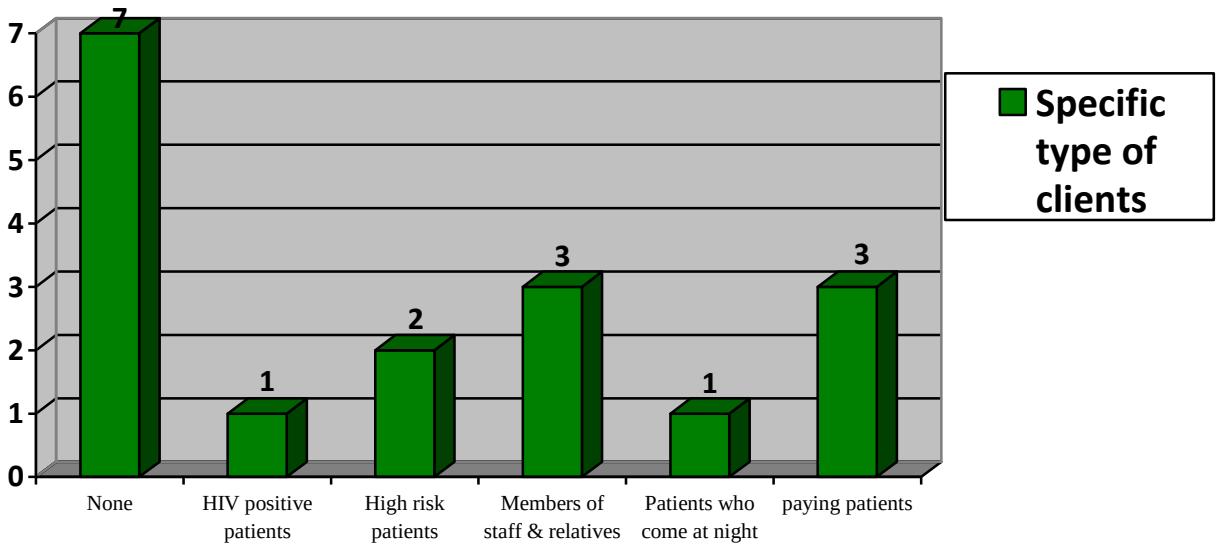
Figure 8: Midwives distress



Specific type of patients that are treated differently

Lastly the midwives indicated that there were some patients who were treated differently. HIV positive patients, high risk patients, members of staff and relatives, and paying patients were treated with more dignity than the others (figure 9). Patients who came at night were not treated with the expected dignity due to inadequate lighting, but also staff shortage or overworked and exhausted staff.

Figure 9: specific type of patients that are treated differently



Qualitative findings and discussions

In the survey questionnaire that was used to collect quantitative data, a semi-qualitative section with open-ended questions was also included. Data were collected from all 126 postnatal mothers and 17 midwives.

The women and midwives expressed their views on understanding of dignity, how they would like to be treated with dignity and why they think some women are not treated with dignity.

The information assisted in isolating factors that influence dignity. The following were the themes that emerged from the content analysis of the responses: reception, midwives attitudes and behavior, patients' attitudes and behavior, communication and management short falls.

The themes that emerged were related to "dignity and place", "dignity and people" and "dignity and processes". The women did not talk much about dignity and place. Below is the presentation of the findings and discussions.

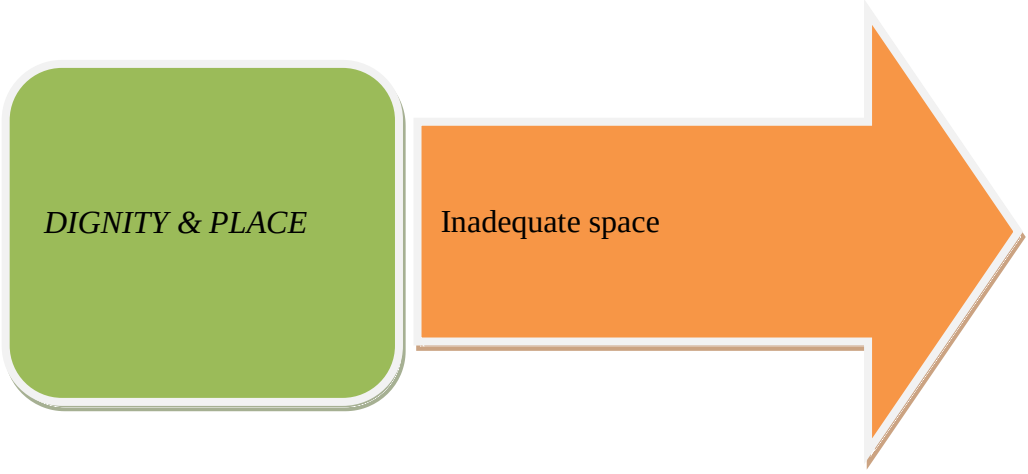
Before presenting the qualitative findings, below is the narration from a postnatal mother. The experience is not unique because some mothers had similar narrations but they ended in delivering their babies on their own in the study sites labor wards and they were not referred to other health facilities. The woman will be called Maria, for clarity of the narration.

Maria said that she arrived at the health facility around one o'clock in the morning with her guardians. She said they were welcomed by a watchman who was rough in his speech. He showed them the directions to the labor ward and went to wake up the midwife on duty from her house. It took 20-30 minutes for the midwife to arrive in the labor ward. Upon arrival the midwife asked if she has brought all the necessary things without mentioning the things. The midwife asked about the health passport, her name, address, age, if it was her first pregnancy, the number of children who were at home. Maria said that when the midwife learnt that it was her third pregnancy and had two living children at home, the midwife responded; "okay you know everything and there is no need for me to give you any information about labor and delivery". Maria then said the midwife went ahead to ask her when the labor started. When she told the midwife that she has been having the labor pains for the past six hours, she was accused of coming to the hospital at that awkward time. The midwife further asked Maria about; the gestational age, how many times she had attended the antenatal clinic and the last time she had an HIV test and where the test was taken. It was only after these questions that Maria was offered a bed where the midwife listened to the fetal heart and did a vaginal examination. The midwife told her that she was not in labor, and that she had to lie on her side and not on her back. The midwife then told her that she would see her later in the day. Maria narrated that immediately the midwife left, the labor pains were becoming stronger and she started screaming with pain. She said the cleaner who was with them in the labor ward shouted at her: "Can you stop screaming I thought you said you already have two children?" Maria explained that the cleaner meant that the fact that she had the two children, it meant that she was experienced with labor pains and was to bear with the pain in silence. She said the cleaner went ahead asking if she was never counseled at home about labor and delivery, what she thought were the consequences when she was 'making' the baby. The cleaner kept emphasizing that her noise was not needed in the labor ward so she has to remain quiet. Maria never stopped screaming completely, she screamed loudly when there was a contraction and stopped in between contractions. The cleaner continuously attempted to make her stop screaming but she reached a point where she would either sit up or come out of the bed just to try to relieve herself from the labor pains. She said she did this more than three times and being fed up with her behavior, at 5am, the cleaner called for an ambulance from the district hospital and went to wake up the midwife Maria said the cleaner told the midwife that she was not cooperative and was being difficult so she had called for an ambulance. She said the midwife found her screaming and sitting up in bed. She reminded

Maria that she was not in established labor and asked her why was she screaming. The midwife told Maria that the ambulance was coming and she was going to the district hospital because they could not keep her at the health centre. Maria was then told to pack her things because the ambulance was almost arriving. Maria explained that she still recalled that the midwife never examined her but she quickly wrote a referral letter and filled in the labor graph because the ambulance had arrived. The woman delivered in the ambulance when they were almost arriving at the district hospital. She was assisted by the guardians. She said upon arrival at the district hospital, the driver went with the referral letter to the midwives in the maternity unit and informed them that the woman had already delivered in the ambulance. The midwives came with a trolley and picked her and the baby to the labor ward. When picking her, the midwives were telling her that what she had experienced was a price of being uncooperative, if she had listened, she wouldn't have delivered in the ambulance. She said when they arrived in the labor ward she was asked to move to a delivery bed so that she could be examined to rule out possibilities of either tears in the birth canal or retained products of conception. The baby was also examined. The baby weighed 3900grams and was alive and well but Maria sustained a tear. Maria narrated that the midwives said that it was because of her stubbornness, if she had been calm like the way she was at the district hospital, she wouldn't have been referred there, neither even delivering in the ambulance nor having a tear. Maria explained that the tear was sutured and she was taken to the postnatal ward around 9am with her baby. The guardians were called to be with her. She said they were not discharged on this particular day because the baby was born after 12 midnight, so they were kept at the postnatal ward.

This story demonstrates that there are unspoken rules for behavior of laboring women, and that if women go beyond these expected behaviors, they are blamed, punished, and not cared for. In this case, what happened to Maria is an indication of non-dignity approach to care.

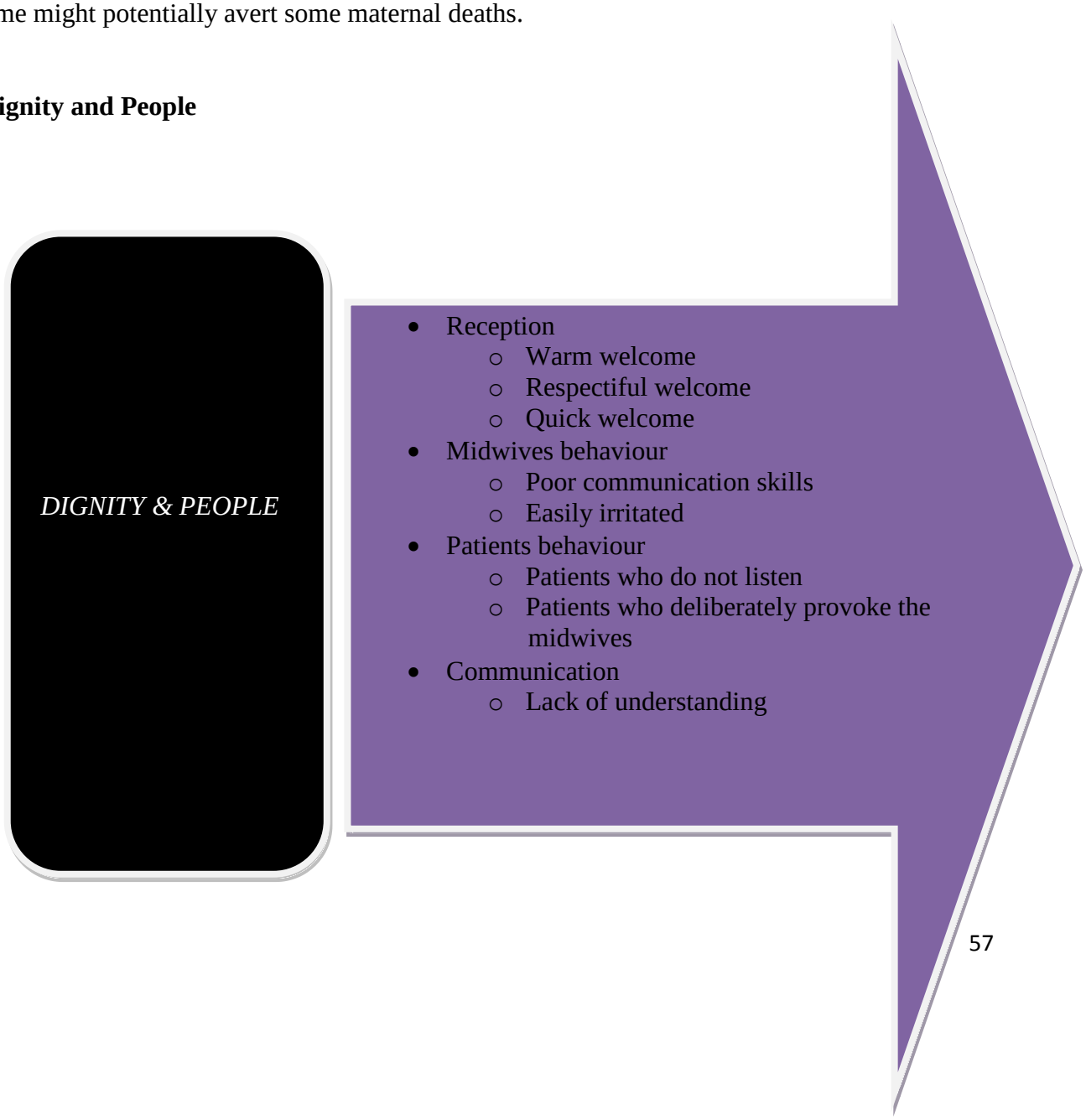
Dignity and Place



Inadequate space

The midwives expressed that their infrastructures are small compared to the number of women they have to serve. They said they end up compromising dignity by having floor beds or discharging the women early from the hospital in order to create space for other women. A woman can stay for a minimum of 8 hours after delivery before discharge. The day duty midwives (those who start work from 7:30 am to 4:00 pm) discharge those who deliver before 12 midnight. It was not established from the postnatal mothers if they were not happy with the discharge arrangement. The policy in the three facilities indicates that the women should be discharged 48 hours after delivery. So the midwives felt that they are sending the women away prematurely due to inadequate space. They would have been happy if the women were monitored 48 hours after delivery, especially since, most maternal death casualties are in the first two days after delivery. Monitoring and caring for them in the hospital during this critical time might potentially avert some maternal deaths.

Dignity and People



Reception

The majority of the women (62%) talked a lot about their first interaction with the midwives. They would prefer a form of welcome which is warm, respectful, and quick. They would like to meet a midwife with good interpersonal skills. They would be happy meeting a midwife who is empathetic, loving, kind, and attentive, a good listener, a good communicator, even tempered, professional and competent. The first interaction is always important as it sets the atmosphere for the whole experience. The women are in a new environment and possibly do not know what to expect. They are in pain and possibly scared. In two of the facilities, the relatives are not allowed to be with the women in the ward. They are kept outside. So the women rely on the midwives who are on duty. Since the majority of the women explicitly mentioned the preferred welcome, it may be a reflection of a profound opposite experience; of not being noticed and acknowledged warmly.

Warm welcome

"PM #1[10]: *They should welcome us warmly."*

Since first impression always set a pace of subsequent interaction between the women in labor and the midwives, a friendly atmosphere is vital. When they arrive at a maternity unit, they need to be acknowledged, noticed and accepted. Many postnatal mothers (36%) expressed a need to be welcomed warmly upon arrival at the maternity unit. One woman from her narrations repeatedly kept emphasizing what she would like to do to make her feel welcome *"**PM #31[11]:** at least they have to greet us."* As some studies have expressed that health care settings can be intimidating and can make one to feel anxious (5;8), I believe these women also felt the same. The way they were treated on arrival in the labor ward was a clear explanation for their passive behavior in other elements of care. This could have possibly affected some of their expectations as such, they were just looking forward to deliver and being discharged home. The findings are in line with what Matiti and Trorey indicated that in a hospital setting, patients will adjust their perception of what is needed to maintain their dignity, not just according to their own values but how ill they are and what they understand they must undergo to get well (56).

[10] She was a 25 years old, married, Christian, from Yao tribe. She is a business lady and a form 2 school drop out. This was her second delivery; she was admitted at 3pm and delivered at 3:20pm.

[11] This was a 37years old married Christian from Lomwe tribe. A business lady and a standard 5 school drop out. This was her 6th delivery, was admitted at 8am and delivered around 1pm.

Most of the midwives (8 out of 17) also mentioned about warm welcome when they were asked to express with examples, their understanding of dignified care. They felt that warm welcome set the tone and mood of interaction and rapport. They felt that it makes the patient feel comfortable and relaxed. The midwives know what is expected of them and what to do but it was not reflected on the care they gave the women. *"**Mid #8**[12]: Warm welcome, greet and offer a chair so that they can feel welcome. Ask their concerns for them to be treated accordingly".*

Respectful welcome

***"PM #63**[13]**:** they have to welcome us in a respectful manner, examine us and listen to us, not just telling us ' go and sleep there'".*

The postnatal mothers (26%) also expressed the need to be welcomed with respect. To them, they feel that being pregnant warrants someone to be treated with respect. Like in communities, pregnant women are given first priority or consideration e.g. when there is one seat, priority is given to pregnant women. So they know that they should be treated with respect regardless of where they are. This also applies to the hospital setting. The maternity unit is specifically created for the pregnant women. They are the consumers and customers of care in that unit.

The midwives also expressed the need to respect the patients on arrival, and not shouting at them as some do. *"**Mid #8:** Upon arrival some midwives just start shouting at a woman say, when a woman has just arrived without a basin, you just start shouting, where is your basin? Where do you think you are going without a basin?"* This is a pretty intimidating comment, making the woman feel little and forgetful. This is the opposite of a respectful welcoming.

Quick welcome

The postnatal mothers (28%) mentioned the need to be welcomed quickly. When they arrive at the hospital they have to be noticed and welcomed there and then. Even though the midwives can be few and busy, they can welcome the women and tell them to wait while they

[12] She was a female midwife, not yet married but was engaged, had no child. Had 1 year experience of working as a midwife, was trained from a CHAM institution, had a diploma in nursing and midwifery.

[13] She was a 29 years old, married, Christian, from Lomwe tribe. A housewife and a standard 4 school drop out. This was her 4th delivery, was admitted at 2pm and delivered at 3pm.

are assisting other women. The woman can feel that the midwives know that she is there. The postnatal mothers felt that at times they were not treated or welcomed quickly because the midwives report for duties late.

> *"**PM #37[14]:** The midwives should arrive at the facilities on time so that they can also assist people on time. We should not arrive and wait for the midwives".*

One midwife also commented on the need of attending to the women with urgency. The midwife felt that by attending to women at the time they need assistance could portray dignified care. This may make the women feel respected and accepted. The midwife further indicated that it is indeed boring for anyone to wait for a long time without being assisted even if it is outside hospital setting. According to Proctors' study, midwives expressed that women in an antenatal clinic setting, when they are not in labor, do not want to wait longer than 20 minutes, women said that they prefer short waiting times, less than 30 minutes (57). However, when in pain they would definitely need less waiting time. This is in agreement with Matiti and Trorey findings that patients' expect prompt attention from the midwives (16).

The postnatal mothers even suggested that since deliveries are often quick and the women need to rest in a bed, the midwives should minimize the number of questions so that they can be assisted quickly. *"**PM #62:** They should ask few questions to avoid women delivering at the admission area".*

Midwives behavior

Midwives, just like any human being, have different characters. The postnatal mothers who were interviewed also acknowledge the same and indicated that there are some midwives who are nice and others are "bad hearted", who were "born cruel" or who consciously attempt to be cruel, and midwives who shout or act rudely. As highlighted above the postnatal mothers expressed that they would like to meet a midwife with good interpersonal skills. They would be happy meeting a midwife who is empathetic, loving, kind, and attentive, a good listener, a good communicator, even tempered, professional and competent. They would prefer a midwife who will not abuse them verbally or physically.

[14] A 17years old, married, Christian of Lomwe tribe. A house wife and standard 2 school drop out. This was her first delivery, was admitted at 12 midnight and delivered around 5:10am.

Both the postnatal mothers (52%) and the midwives (8 out of 17) indicated the midwives behavior as one factor that affects provision of care with dignity to the women. The midwives said that some midwives are rude, harsh, have poor communication skills, are easily irritated, like shouting, insulting, "they do not have a caring heart, and some favor women who came to the hospital clean and smart". One midwife said *"**Mid # 16[15]:** patients from the rural are treated with less respect but those who are clean and smart are treated with respect because it is assumed that they know their rights*". Dignity applies to all, regardless of ethnicity, socio-economic status or background. It is non discriminatory (58).

"Midwives with poor communication skills, who shout or act rudely"

***"PM #32[16]:** Some show love, some just shout at us, they have different behaviors, and the type of care we receive depends really on who is on duty on that particular day".*

Sixteen percent of the postnatal mothers expressed that some women lose dignity during labor and delivery because of the way the midwives talk to them. They indicated that some midwives either shout at them or are rude to them. These postnatal mothers' feelings were similar to those expressed by women in Frasers' study, they did not like midwives who were rude and shouted at them. The study emphasized that every human being values being talked to in a nice way, not in an embarrassing way. Being embarrassed especially in front of others reduces ones' dignity (59).

Having good communication skills is one trait of a good midwife (60). The midwives accepted that their communication skills sometimes were not good and contributed to the women losing their dignity. The postnatal mothers also expressed that some midwives shout in response to patients' behavior. They relate the midwives' behavior with any ordinary individual, where one can shout in response to an unacceptable behavior. As midwives, they have professional obligation from the training that they underwent and they know what and how to conduct themselves.

"Midwives who are easily irritated and do not have a "caring heart""

Seventeen percent of the postnatal mothers indicated that some women are not treated with dignity because the midwives are irritated with the women's behavior.

[15] A female midwife, married with two children. Had 11years experience of working as a nurse midwife. A registered nurse midwife with a diploma.

[16] A 31years old, married, Christian, of Ngoni tribe. A housewife and standard 8 school drop out. This was her 5th delivery, was admitted at 8pm and delivered around 10:15 pm.

*"**PM #14**[17]**:** Some midwives they tell you in advance that "do not scream, just breathe out", so when you scream, they get bored with you and they leave you to deliver on your own".*

The postnatal mothers and the midwives further narrated that; personal problems, tiredness from over working or personal issues/errands, the remuneration package they get at the end of the month were the common reasons for midwives irritability;

"***PM #87**[18]**:** Some midwives are already tired or are angry by the time they report for duties, they just shout at people"*

*"**Mid # 3:** Some it is the workload that makes them to be easily irritated."*

"***Mid # 3:** With the little salary that we get, at times some they do not have adequate meals before coming for work so they are easily irritated because they have their own problems."*

Individual differences can also play a role, in the same setting, being exposed to the same factors, some midwives were said to be nice while others not. The "caring heart" overrides the reasons for being easily irritated. A midwife who is caring may not be shaken by other factors. Moore et al presented some of the midwives' caring behaviors which include: attending to human needs, being accessible to patients, attending to emotional needs, respecting human dignity/rights, informing/explaining/instructing, involving family and incorporating cultural context (61). Both the midwives and the postnatal mothers expressed that some midwives are not caring; hence they treat women with less dignity.

*"**Mid # 17**[19]**:** Some midwives just joined the profession for the money but not to assist patients; they don't have a caring heart."*

*"**PM #51**[20]**:** Some midwives think of others while others do not, so when you meet those who do not think of others you do not receive appropriate care."*

[17] A 23years old, married, Christian of Mang'anja tribe. A housewife and standard 7 school drop out. This was her 4th delivery, was admitted at 10pm and delivered around 6am the following morning.
[18] A 27years old, married, Christian of Lomwe tribe. A housewife with a Malawi school certificate (form 4). This was her second delivery, was admitted at 5am and delivered around 1pm.
[19] A female midwife, widowed with more than 4 children. Had 30 years of working as a nurse midwife, with a certificate in nursing and midwifery obtained from a CHAM institution.
[20] A 20 years old, married, Christian, of Yao tribe. A house wife and standard 7 school drop out. This was her 2nd delivery, was admitted around 5am and delivered around 7pm.

The postnatal mothers felt that some of the midwives do not have a caring heart because they:

1. Are bad to the core: *"**PM #32:** Some midwives have bad hearts even before being midwives; their life is just like that."*

2. Have a superiority complex**:** ***"PM #35[21]:** Some midwives feel that when they are midwives or doctor's people fear them so they treat others with no respect." "**PM #9[22]:** Rude midwives, they just feel that the patients can not take a pencil and write drugs for themselves, even though they can do that, they will still wait for the midwife."*

3. Have no love: "***PM #92[23]:** The midwives do not have love, they just shout when the patients are making noise." "**PM #61[24]:** Some midwives they don't have a helping heart, they don't love other people."*

4. Are cruel or bad mannered: *"**PM #115[25]:** Some midwives are bad mannered they insult, beat up people without a reason." "**PM #113[26]:** Some midwives are just cruel so they just treated others badly without a reason." "**PM #97[27]:** Some midwives have a bad life they can just be staring at the patients without taking care of them."*

5. Are not serious with their work: *"**PM #111[28]:** Some midwives do not consider their work." "**PM #122[29]:** Some midwives are not serious with their work."*

All the above stated reasons are negative attributes of a midwife. A midwife with positive attributes uphold a caring, supportive and trusting relationship with women in labor (60).

[21] A 36years old, married, Christian, of Chewa tribe. A teacher. This was her 6th delivery, was admitted around 6am and delivered around 1:50pm.
[22] A 28years old, married, Christian of Lomwe tribe. A housewife and standard 2 school drop out. This was her 6th delivery, was admitted at 8pm and delivered around 1am.
[23] 15 years old, single, Christian, of Lomwe tribe. Not employed and a standard 6 school drop out. This was her first delivery, was admitted around 12 noon and delivered around 2pm.
[24] A 30 years old, married, Christian of Lomwe tribe. A housewife with Malawi school certificate of education. This was her 3rd delivery, was admitted around 2am and delivered around 12midnight starting the following day.
[25] A 17years old, married, Christian of Lomwe tribe. A housewife and standard 3 school drop out. This was her first delivery, was admitted around 7pm and delivered around 8pm.
[26] A 26years old married Christian of Lomwe tribe. A housewife and standard 4 school drop out. This was her 6th delivery, was admitted at 12midnight and delivered around 1am.
[27] A 20years old, married, Christian of Lomwe tribe. A housewife and standard 6 school drop out. This was her 3rd delivery, was admitted around 4am and delivered around 3pm.
[28] A 24years old, married, Christian of Lomwe tribe. A housewife and standard 6 school drop out. This was her 3rd delivery, was admitted at 10am and delivered around 11am.
[29] A 25years old, married, Christian of Chewa tribe. A housewife and standard 6 school drop out. This was her first delivery, was admitted at 4pm and delivered around 5pm.

Almost all the postnatal mothers who talked about the midwives being cruel, felt that it was an innate thing that the midwives were born like that. Even though the postnatal mothers acknowledge that the cruelty was inborn, they still expressed feelings that it was unacceptable. It can be a challenge to exclude the cruel midwives from practicing in this setting where there is a shortage of midwives. It is even difficult to identify and describe cruelty in detail. But if there is a will, the behavior can be changed.

Patients' behavior

"PM #12: *Sometimes the patient behavior makes it that she should not be treated with dignity."*

Both the postnatal mothers (77%) and the midwives (8 out of 17) felt that the women themselves also contribute to them not being treated with dignity during labor and delivery.
The postnatal mothers agreed with the midwives that there are some patients who behave in ways that are "frustrating" or "tiring" for the midwives like:

- Patients who don't listen to the midwives or follow instructions correctly
- Patients who deliberately attempt to provoke the midwives or who are rude

"Patients who don't listen to the midwives or follow instructions correctly"

"PM #8[30]: *Usually the person that is treated with no dignity is the one who either did not follow the rules or instructions."*

Both the postnatal mothers (32%) and the midwives (4 out of 17) expressed that failure to follow instructions or to listen warrant a woman who is in labor not to be treated with dignity.

> ***"PM #73[31]:*** *At times the patients does not do what they are told, when they listen to the midwives everything goes on nicely."*
>
> ***"Mid # 8:*** *Some patients are uncooperative; they start pushing when the time is not yet so the midwife can get upset, Some scream too much, make noise, and walk unnecessarily so it irritates the care giver and shout at the patient"*

[30] 17years old, married, Christian of Lomwe tribe. A standard 8 school drop out and housewife. This was her first delivery, was admitted around 12noon and delivered around 3pm.
[31] 18years old, married, Christian of Lomwe tribe. A form 2 school drop out and a housewife. This was her first delivery, was admitted around 1pm and delivered around 8:30pm.

The postnatal mothers strongly believed that if one follow rules and instructions, that one is treated with the expected dignity. One of the midwives also commented that those women who do not follow "rules", irritates the midwives and the women are left unattended in turn. This is a bit alarming, as there are not really any norms for how one behaves during a painful labor and probably fearful too. While in Proctors' study, midwives expressed that women want to be listened to, midwives should be approachable and trustworthy, not that women should be listening to whatever the midwife says (57). In this study, it was revealed that the women who are in labor have a duty to listen to midwives and follow instructions. From the postnatal mothers' narrations, one can tell that the women who are in labor in the study sites; were given the following "rules":

1. Do not scream
2. Sleep/lie on your sides
3. Do not walk unnecessarily
4. Do not make noise
5. Do not bear down when you are not instructed by the midwife
6. Listen and do according to what the midwife tells you.

This is a fairly top-down attitude to patients, that they should attempt to be invisible, unproblematic, passive, non-initiative, and "not in the way". It is quite contrary to modern delivery care where motility, urgency and active management are the norm (32). The midwives portrayed traditional or cultural beliefs associated with labor and delivery without incorporating modern midwifery practices. The patients' "misbehaviors" or the "rules" above, have a cause. If the midwives consider why the women are screaming or changing positions now and again, they would treat the cause. If the women's pain were managed properly, there would not have been accusations of making noise or screaming too much.

"Patients who deliberately attempt to provoke the midwives or who are rude"

"PM #6: *Some patients are difficult; they deliberately provoke the midwives so the midwives find it difficult to contain it."*

The postnatal mothers (15%) and the midwives (5 out of 17) agreed in saying that there are some women who were not treated with dignity because they were deliberately provoking the

midwives. It was felt that it was hard for the midwives to contain such behaviors. Sometimes it was the way the patients approached the midwives. When the patients approached the midwives in a manner that they rank themselves to be of very high importance, the midwives would want to show them that the midwives were in control. So the patients ended up being treated with no dignity. It is like there was a power conflict that both feel that they were ranked higher than the other. So since the patient went to seek care from the midwives, the midwives win because they are the one giving the services. The midwives also added that some patients want impossible things, they come with negative attitudes so it was difficult to accord such patients with the expected dignity. At times the patients provoked the midwives through their actions: the way the patients refused to be examined, the way they wanted to express themselves on other simple matters and the way the patients wanted to make use of their rights without taking responsibilities.

> ***"PM #90[32]:*** *It is because the patients are difficult; when you are calling the midwives now and again they become angry."*
>
> ***"Mid # 13[33]:*** *The approach of the patients, at times they want impossible things so the provider become upset so you just let it be. Mostly the majority came with a negative attitude."*
>
> ***"PM #126[34]:*** *Some patients are difficult they refuse to be examined they put their legs together so when they completely refuse the midwife becomes angry."*
>
> ***"Mid # 9:*** *The issue of patients rights because it is highlighted more than health workers rights so the patients do or behave in a way they want."*

One midwife felt that at times the midwives takes advantage of the patients' ignorance of their rights to treat them in an undignified way.

> ***"Mid # 15[35]:*** *Most patients especially the non paying patients they don't know their rights so they do not complain"*

[32] A 19 year old, married, Christian of Lomwe tribe. A housewife and form 2 school drop out. This was her first delivery, was admitted at 1am and delivered around 2pm.
[33] A female midwife, married with 3children. Had 24 years experience of working as a nurse midwife, with a certificate in nursing and midwifery obtained from CHAM institution.
[34] 27years old, married, Christian of Ngoni tribe. A housewife and a standard 3 school drop out. This was her 5th delivery, was admitted around 8am and delivered around 4pm.
[35] A female midwife, married with a child. Had 20 years working experience as a nurse midwife. Had a certificate in nursing and midwifery obtained from a CHAM facility.

It is unfortunate that the midwives were taking advantage of the women's ignorance. Midwives should not wait for a woman to complain in order to give dignified care. Treating non paying patients with no dignity is contrary to midwifery standards set by the Nurses and Midwives council of Malawi (32). It portrays that the midwives are not fulfilling their roles and responsibilities as stipulated in the standards.

Communication

Poor communication influenced the degree to which postnatal mothers and the midwives understood each other. Both parties (postnatal mothers 13% and midwives 3 out of 17) said that lack of understanding between the midwives and the women resulted in some women being treated with less or no dignity. At times the patients did not understand the hospital procedures.

> ***"PM #11[36]:*** *The midwives should be able to understand. The problem is when you do not understand each other."*
>
> ***"PM #20[37]:*** *It is what the patients do. They do not understand what the midwives are telling them."*
>
> ***"Mid # 7:*** *It is because of poor communication with patients (we do not understand each other)"*

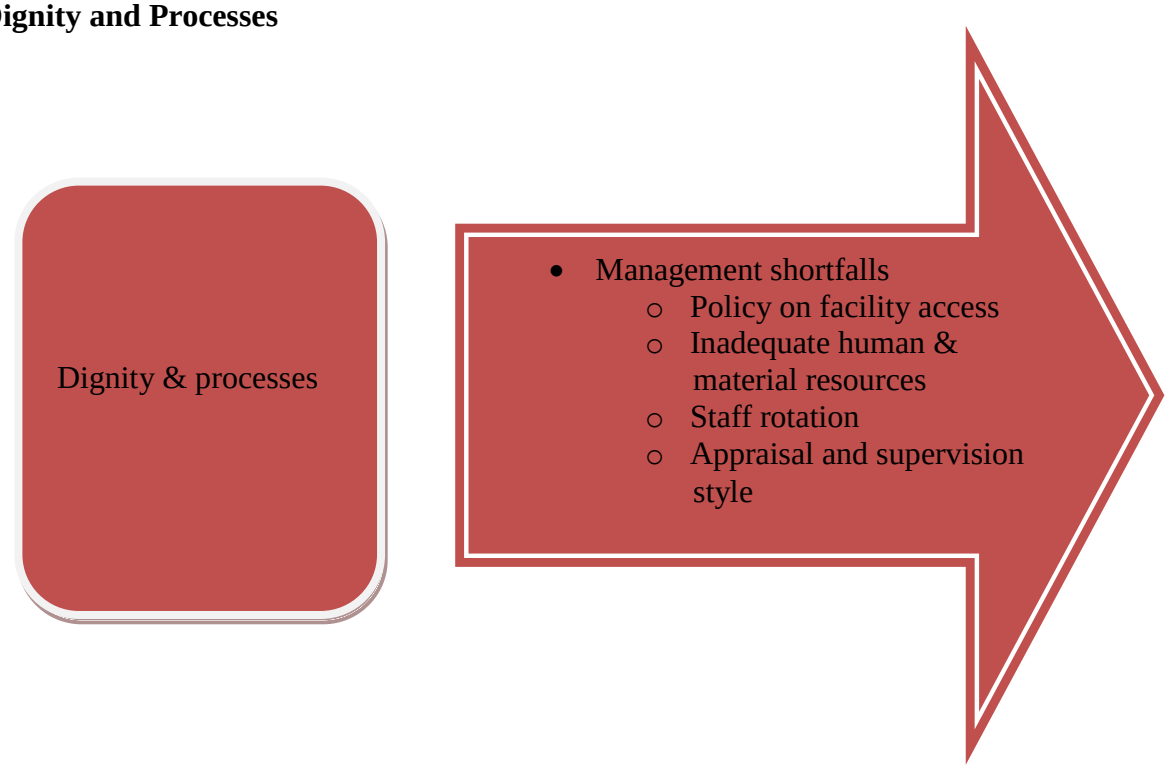
This 'understanding' goes back to their respective roles, responsibilities, and expectations. According to patients' rights and responsibilities, the women had a right to understanding. The women had an obligation of expressing themselves fully to the midwives and making sure that they have understood (58). On the other hand the midwives had a duty of making sure that they were giving accurate, truthful information that was presented in a manner that could be easily understood by the patient. The midwives also had a duty to understand the labor process that the effects can interfere with the rate at which a patient can understand information or the way the patient can convey information. The bigger role still remains with the midwife to make sure that both parties understand each other. The labor ward could have been a therapeutic place if the midwives followed their professional script and utilize knowledge gained through their training. Frasers' study found that communication abilities of

[36] 18years old, married, Christian, of Lomwe tribe. A housewife and a standard 8 school drop out. This was her first delivery, was admitted around 10pm and delivered around 9am.

[37] 33years old, married, Christian, of Ngoni tribe. A housewife who had never gone to school. This was her 3rd delivery, was admitted around 1am and delivered around 6am.

the midwife was of paramount importance throughout the childbirth process (59). Midwives should seek confirmation that patients understand what has been communicated (53).

Dignity and Processes



Management short falls

Both the postnatal mothers and midwives felt that some women were not treated with dignity because of administrative arrangements. Some of the postnatal mothers felt that the referral policy, shortage of midwives and overstaying of a midwife at a facility threatened their dignity. A majority of the midwives said that shortage of midwives, inadequate material resources, no appraisal and supervision style adversely affect their attempts to deliver dignified care to their patients as discussed below:

Policies

"PM #2: *The rules hinder on our freedom, they say that in order to be treated at this hospital you have to be sent by your nearest hospital and you should have a written document."*

Some delivery of care arrangements affects the dignity of pregnant women. The stipulation that one must first be treated at a facility near her place of residence infringe on the women's right to choose a facility of her preference for health services. According to Malawi's health

delivery system, the services are offered in three levels. The system highly encourages the use of primary services. It saves the secondary and tertiary levels for those who have been referred on the discretion of the referring unit. If it leaves the services open, then there would be over crowding in tertiary and secondary levels with patients who can benefit or be treated better at a primary level. The crowding can delay access to those in need of secondary or tertiary services.

At primary level, the services are offered by the lower cadre of the health professionals in Malawi, the medical assistants and nurse midwife technicians. Most often the primary levels have inadequate resources compared to the other levels. The situation drives some other residents, who have better resources, to seek better services from private institutions or to go to the secondary or tertiary institutions.

Inadequate material and human resources

The midwives (3 out of 17) indicated that the facilities had inadequate linen, plastic sheeting material (mackintosh), plastic papers, scissors and few other resources. They felt that if they had adequate resources women would receive dignified care.

> *"**Mid # 15:** Lack of resources both human and material to use when working, so patients are not monitored as required and they cannot be given necessary items like linen"*

The inadequate material resources require the midwives to improvise. It has leaded them to start devising creative ways of finding resources. Like the use of plastic papers for plastic sheets to avoid soiling the mattress for infection prevention purposes.

Both the postnatal mothers (11%) and the midwives (9 out of 17) felt that there are an inadequate number of midwives and that this may be one reason that some women are not treated with dignity. The shortage of staff led to high workload; pressure of work; exhaustion or working 24 hours. These have negative effects on the midwives and consequently they end up compromising the way they deliver care to their patients. The patients who are placed in first stage of labor room end up not being monitored in most occasions because of the shortage. Even those in the labor ward are not monitored according to standards because the midwives prioritize assisting deliveries to monitoring labor progress.

Shortage of staff also led to overstaying (being at one facility for more years) of a midwife at a health centre. The midwives are not rotated after every two years as scheduled. Seven percent of the postnatal mothers felt that overstaying of a midwife at a health centre is not good because the midwives get used to the environment and start behaving in an unacceptable way.

Appraisal and supervision style

The midwives also complain on the way they are handled by their supervisors. They said that during supervision, their supervisors do not acknowledge when they have done something good. They only point out the bad things. The midwives are shouted at in front of patients. Therefore they become demoralized and frustrated and in turn they treat their patients with less or no dignity. This is in contrast to all behavior research, which shows that positive feedback and incentives are better modifiers than punishment (62).

> ***"Mid # 12:*** *We have some midwives who are nice and kind but they are de-motivated with the way the bosses speak to them and what they do is not recognized so they backslide."*
>
> ***"Mid # 13:*** *At times the supervisors do not approach the juniors in the right manner, when one has made a mistake is shouted at in front of everyone including patients."*

For Supportive supervision to yield better results it has to be firm but fair (62). Supportive supervision can have an impact on the midwives attitudes and behavior when they are frequently monitored and when it is coupled with rewards and sanctions. Giving midwives clear standards and feedback on the provision of dignified services, can improve their attitudes and behavior towards patients.

Summary of findings

From the findings above, we can say that the following were the factors that influence dignity from the study sites:

Table 4: summary of findings

FACTOR	PROMOTES DIGNITY	COMPROMIZE DIGNITY
Dignity and place 1. Inadequate space	When only one patient or few patients are in labor	By taking history and asking personal questions in front of others Having crowded ward with floor beds No space for laundry and personal belongings
Dignity and people 2. Midwives attitudes and behavior	Directing/escorting women to the labor ward Providing privacy through covering the women, not exposing women unnecessarily, use of screens, and use of low tone for audio privacy Good communication skills: listening carefully, explanations, not shouting Caring behavior: giving assistance as soon as it was needed, giving care according to women needs and choices, courtesy and respect, being there for women, being nice to women Positive attributes of the midwives: good interpersonal skills, empathetic, loving, kind, attentive, a good listener, a good communicator, even tempered, professional,and competent	Poor reception given to women Non-caring behaviors: abandoning women, shouting, asking women to clean delivery beds, asking women to mop the floor, asking women to wash hospital linen, being authoritative, "rushing" women Negative attributes of the midwives: poor communication skills, rude, shouting, easily irritated, "no caring heart", cruel, "bad hearted"
3. Patients' attitudes and behavior	Being respectful to midwives Listening to midwives	Screaming Making noise

	Following instructions Understanding instructions Being sympathetic and empathetic with the midwives.	Walking unnecessarily Calling midwifes frequently Refusing to be examined Pride Negative attitude towards midwives' and the hospital. Rudeness Expressing rights without taking responsibilities Ignorance of patients rights
Dignity and processes 4. Inadequate resources (Human & material)	Innovative Improvising	Having floor beds Beds without linen Discharging women early High workload Pressure of work Exhaustion Working 24hours Midwife staying at a facility for many years
5. Polices that hinder freedom to access health facility of choice	Creates adequate room for those in need of services provided at referral units.	Deny access to health facility of choice.
6. Supervision style	Staff appraisal Positive feedback Consistent supervision	Shouting juniors in front of patients. Emphasizing on negative points.

Suggestions on improvement in situations where dignity was compromised

With reference to the summary table on the part where dignity was compromised, the following may be done to minimize the loss of dignity:

Dignity and place

Issue:

Inadequate space led to having crowded ward with floor beds and having no space to use for laundry of personal belongings. It also led the midwives to take history and ask personal questions in front of others.

Suggestion for improvement:

Infrastructure adjustments to have more rooms to provide privacy and more space to accommodate the women.

Dignity and people

Issue: Midwives attitudes and behavior:

Some midwives had negative attitudes and behaviors that made them to give poor reception to the women. Some had non-caring behaviors that led them to; abandon women, shout, ask women to clean delivery beds, ask women to mop the floor, ask women to wash hospital linen, being authoritative and being in haste when interacting with the women. The negative attributes of some of the midwives were: poor communication skills, rude, shouting, easily irritated, “no caring heart”, cruel, and “bad hearted”.

Suggestion for improvement:

- Midwives to be reminded about professional ethics
- Midwives to be refreshed on dignity
- Continuous counseling of the midwives
- Continuous supportive supervision and monitoring
- Putting measures to communicate and enforce professional practice
- using sanctions for non caring behaviors and poor attitudes in ways that are fair and consistent
- create mechanisms for patients to complain
- educate patients on their right for dignity

Issue: Patients attitudes and behaviors:

The following attitudes and behaviors displayed by some women made them to receive undignified care from the midwives; screaming, making noise, walking unnecessarily, calling midwives frequently, refusing to be examined, pride, negative attitude towards midwives' and the hospital, rudeness, expressing rights without taking responsibilities and ignorance of patients' rights.

Suggestion for improvement:

- Publicizing patients rights and responsibilities
- Publicizing health workers rights and responsibilities
- Patient education on their expectations in the labor ward
- Provision of pain relief measures and managing patients problems professionally
- Proper patient-midwife communication

Dignity and processes

Issue: Inadequate resources:

Lack of resources led the women to sleep on floor beds and on beds without linen and to be discharged early from the health facilities. It made the midwives to have high workload, led to pressure of work, exhaustion, made some of them to work 24hours and some to stay at a facility for many years.

Suggestion for improvement:

Material resources:

- devise measures for equitable distribution of resources
- devise measures for appropriate improvising on the unavailable resources
- devise measures to source funds to supplement the resources
- source for internal and external donations

Human resources:

- devise measures on training, recruitment and retention of the midwives
- Equitable distribution of the few midwives
- Devise measures for proper scheduling of midwives duties for example utilization of split shifts, flex hours, team based self rostering with consideration of grade/skill mix

- Fair staff rotation to avoid over staying at one facility incorporating views of staff and service users

Issue: Policy:

The policy of getting primary health services from a health facility in the catchment of the women residence made some women to have no access to health facility and health professionals of their choice.

Suggestion for improvement:

Dialogue with the community and other significant stakeholders on how best the policy can be implemented

Issue: Supervision style:

Poor supervision skills of some supervisors made them to shout at their juniors in front of patients and to emphasize on negative points only without acknowledging the strengths.

Suggestion for improvement:

- Supervisors to be refreshed on supervision skills
- Supervisors should make the midwives to feel valued and recognized by rewarding and giving feedback on good performance

The interventions that have been suggested for improvement, some of them are long term and require decisions by higher levels for instance suggestions on infrastructure and shortage of midwives. Some can be introduced by managers of the facilities, they can focus on things that they have direct influence. The interventions can be directed to the overall system, facility, team or at individuals.

The midwives are expected to handle themselves with integrity, unselfishly, prioritize patients' interests over their own, and to utilize technical expertise. Those who cannot conduct themselves, they need to be supported by the supervisors. Interactive in-service training can change midwives behavior if it is followed with intermittent enforcement and support (62).

The quantitative findings indicated that the majority of the women were treated with dignity, while the qualitative findings illustrated that the women were treated with less dignity. If the study had approached the question in a quantitative way, the findings would have shown that the majority of the women are treated with dignity and the factors solicited would have explained more on promotion of dignity. On the other hand if it took a qualitative approach it would have been the opposite.

The qualitative method assisted in getting an in-depth understanding of dignity situation in the study sites. Since there was little information about dignity from the study sites and country, the quantitative part did not cover a lot of issues that were expressed in the qualitative section. So it assisted in gaining better understand on the factors that may influence dignity in the study sites, in Malawi.

The qualitative findings enriched the quantitative findings and vice versa. The qualitative part helped to give explanations to the portrayed behaviors by both the midwives and the women.

Methodological issues relevant for this study

The following were the challenges encountered while utilizing the selected data collection methods and approaches.

Study design

A cross sectional survey with structured questionnaires (with both quantitative and qualitative questions) was used to collect the information. The study would have collected more information if more than one data collection methods were used. Observations during labor and delivery process could have been an effective approach to combine with the interviews. In-depth interviews with the postnatal mothers, the midwives and other significant groups as indicated below would have assisted to get a deeper understanding of their experiences with regard to dignity. Pure qualitative approach would have been an alternative to answer the research question. It could have assisted to explore the factors more and to get a deeper understanding of the dignity situation in the study areas.

Study population

The initial target of the study was the mothers. In order to get a deeper understanding the study also included the midwives. To strengthen the findings the study should have also

sought views of the cleaners, guardians, the supervisors of the midwives, doctors and clinical officers working in labor and postnatal wards.

Sample size determination

The sample size determination in this study was done using tables as expressed in the methods section. These tables are used in a "cookbook" manner. The researcher decides on the study design, determine the levels of significance, precision and operational constraints such as time or resource limitations before using the tables (43). Using these tables, one has to use random sampling to draw the sample. Simple random sampling was used by tossing a coin. It would have also been good using random numbers whereby on daily basis new numbers would have been used.

Sample size distribution over the three facilities

The initial plan of the study was to determine and compare the factors over the three levels of care in Malawi. As such equal sample size was required. When it changed to general generalization the distribution of the sample was not considered. It would have been ideal if proportions depending on the number of deliveries of the facilities were used.

Sample size

The calculated sample size for the postnatal mothers was 119. With the previous idea of having equal sample size for the facilities it was rounded to 120. During data collection 126 interviews were conducted. At the last facility two extra interviews were conducted, making a total of 42. Upon realizing the researcher decided to interview more women from the other facilities to have equal numbers. It would have been ideal for the researcher to be alert to stop the interviews upon reaching the required number. Further to that it would have been a good idea to drop the extra cases from the facility it exceeded unlike going back to the other two facilities to interview additional participants.

Choice of facilities

The method used to decide on the study site did not have a scientific basis in that it did not purposely consider the level of dignified care offered in the facilities as there was no much information. The choice was based on closed links in terms of referral services, a health centre which refers their patients only to the selected district hospital, and a district hospital that

refers their patients only to the selected central hospital. The pattern could have been found with other facilities in the central or northern region but the search was limited to the southern region. To make the selection scientific, the researcher could have looked into issues of complaints related to dignified care in the health facilities of the study country through the previous press publications (discourse analysis- newspapers) or through the regulatory bodies.

Response rate

Out of all the postnatal mothers who were invited to participate, none of them declined. In relation to the midwives, out of the twenty midwives who were invited to participate, three midwives declined to participate. They did not decline directly because they were just postponing the interviews, so it was concluded that they did not want to participate. From the 20 midwives who were asked 17 participated giving a response rate of 85%, creating a minimal potential of biased results.

Reliability

"Reliability" is the term used in assessing the extent to which a measurement yields the same results each time it is repeated (42). A structured questionnaire was used to collect the data. Marshal et al indicated that important information is usually missed with structured questionnaires because spontaneous remarks by respondents are not recorded or probed (42). However, they also pointed that repeated interviews with the same data collection tool or method yield same results. In this study the midwife tool was used on 17 midwives and the postnatal mothers' tool was used on 126 women. The use of two different approaches in this present study has also contributed to the reliability in this study. The tools used had open ended questions where respondents were free to give in more than the pre-coded questions.

The pre-testing of the questionnaire before the data collection could to some extent increased reliability of the results. Using one interviewer at all times tends to fastened consistency and by so doing improves reliability. The researcher was the sole interviewer. This also provided the researcher with some qualitative insights through observing the respondents reactions during the interviews; which have been useful in interpreting the findings in the discussion.

The women were also interviewed before discharge which was within 12 hours after their labor and delivery experience. This reduced recall bias because the experience was still fresh.

Validity

Validity entails assessing the extent of what was intended to be measured was actually measured. As the questionnaires were prepared in English, the postnatal mothers' questionnaire was translated into Chichewa. It was noted during analysis that one question lost its meaning due to translation. However, the pre-testing has to a large extent improved both validity as well as reliability because it assisted in bringing to the surface other issues that were addressed before the commencement of the study. The use of both qualitative and quantitative methods to collect data heightened the validity of the study because the information from the two approaches balanced each other. To further increase the validity of the results, the researcher could have utilized more than one data collection approach in this study.

Strengths of the study

Research on factors that influence dignity in maternal health service delivery in Africa has been limited (4), and none has been conducted in Malawi. This study is unique because of its focus on these issues in Malawi, and more particularly because it has demonstrated that there are issues to do with dignity in maternal health service delivery, ranging from the physical environment, the individual behaviors of midwives and patients, care processes and managerial issues.

Limitations

In addition to factors indicated on methodological issues above, to organize a broad and complex topic as dignity is, require some simplification, this might have hidden significant distinctions or barred essential points.

Even though the researcher started by finding out the meaning of dignity from the study sites and their expectations of dignified care through focus group discussions, views of only a few people were heard. Furthermore the quality of the information gathered from the FGDs was not satisfactory. Luckily the question on the understanding of dignity was also included in both the midwife and postnatal mothers' questionnaires. So the researcher was able to gain the understanding of how the postnatal mothers and the midwives view dignity.

Conclusion

Having adequate space and a favorable physical care environment, supervision style and individual midwives and patients' actions can do much to promote the dignity of women during labor and delivery.

The day to day management of a health facility is fundamental in how care is organized and delivered, and is therefore influential in shaping the kind of patient interactions.

Midwives' attitudes and behavior are paramount in influencing the dignity of their patients. They need to display fairness and compassion, listen carefully, take steps for improvement when necessary, and respond caringly. Patients desire the availability of midwives during labor and delivery. Utilizing professional knowledge in combination with good human nature perfect the kind of dignified care that can be given to patients. Verbal interactions can be influential in communicating kindness and respect to patients. The expressions midwives use could convey respect for patient dignity.

Patients' attitudes and behavior influence the way in which care activities are rendered to them. Patients have an obligation to understand their health rights and responsibilities and utilize them dutifully.

Although it is acknowledged that the concept of dignity is complex and demanding, women need to be treated with respect and dignity during labor and delivery, as owed to them by the fact that they are human beings.

Recommendations

Authorities have to make sure that standards are met in structures where labor and delivery services are provided. There is need to have adequate space and resources for the midwives to offer dignified services. There is a need to check the size of the infrastructure against the population it serves and make necessary expansions.

Midwives should reorient their caring practices to more appropriate with regards to evidenced-based midwifery practice. The women should be treated with respect,

understanding and dignity. Action is needed to improve midwives' attitudes towards the women.

The women need to be oriented to their health rights and responsibilities. This may help them to utilize the health rights dutifully and appropriately.

The management of health facilities ought to ensure the provision of dignified services. Sufficient staff and material resources should be available in health facilities to meet the demands of patients' dignity. Continuous supportive supervision should be carried out in a motivating manner. Instill the spirit of respecting one another's dignity among the midwives. Continuously monitor midwives actions towards colleagues and patients and take appropriate action.

Way forward for the researcher

As the researcher is interested in gaining more knowledge about dignity in the health delivery services in Malawi, the next steps are to:

1. Determine the number of complaints related to dignified care in the health facilities of the study country. The complaints will be limited to nursing and midwifery services and those that reached the regulatory body.

2. Conduct a discourse analysis to explore what is being discussed in the media about dignity in maternal health service delivery. The search will be based on the two local papers of the study country (the Nation and the Daily Times).

3. Conduct a follow up study from the same study sites addressing the limitations of the current study.

4. Conduct a new study targeting the facilities with high prevalence of complaints related to dignified care in health facilities.

Call for future research

This study exposed several issues that could be the focus of future research. Some research questions could be:

1. To what extent do Malawian women understand their health rights and responsibilities?
2. In what manner do Malawian nurses and midwives' preserve/protect their own dignity?
3. What is the impact of having adequate staff and good working conditions on provision of dignified care?
4. To what extent do health policies, midwifery and nursing curricula preserve patients' dignity?

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Appendix 1: Information sheet

English version

STATEMENT OF THE STUDY

PURPOSE

I am Lucy Chigwenembe, a Registered Nurse and a researcher currently studying at the University of Oslo in Norway.

You are invited to participate in a study on dignity in maternal health service delivery. The objective of this study is to find out factors that promote or compromise dignity during labor and delivery.

PROCEDURES

Specifically you are going to be asked questions to get your views on dignity during labor and delivery, looking at the physical environment, attitudes and behavior of midwives and the care activities.

The information will be kept confidential. Only the researcher and her supervisors will have access to the information. The information will be kept under lock and key during the course of the study and it will be destroy after the study.

BENEFITS OF THE STUDY

By participating in this study, you will help to increase the understanding of dignity and the needs of patients and service providers as regards to dignity. We hope that the results of this study will improve the delivery services currently available to you.

Your participation in this study is voluntary and you have the right to refuse to participate or not to answer any question that you feel uncomfortable with. If you change your mind about participating during the course of the study, you have the right to withdraw at any time.

If there is anything that is not clear or you need further information, you are free to ask. When you decide to ask later, you can contact me on +265 888 857 679.

DECLARATION OF THE RESPONDENT

I have read the above information, or it has been read to me. I have been given the chance to ask questions about the study and any question that I have asked have been answered to my satisfaction. Therefore, I consent voluntarily to participate in this study.

Signature/Thumb print of respondent: Signature of interviewer:

Date: Date:

Chichewa Version

CHOLINGA CHA KAFUKUFUKU

Dzina langa ndine Lucy Chigwenembe, ndine namwino komanso ophunzira kusukulu ya zachipatala ku Oslo md'ziko la Norway.

Mukupemphedwa kutenga nawo mbali mukafukufuku ofuna kudziwa momwe amai amasamalidwira akapita kuchipatala kukachira. Cholinga chachikulu ndichofuna kudziwa zomwe zimapangitsa kuti amai asamalidwe mwaumunthu kapena ayi pamene apita kukalandira chithandizochi kuchipatala.

NDONDOMEKO

Panthawi yazokambiranazi ndikufunsani mafunso osiyanasiyana ofuna kudziwa maganizo anu pa za momwe amai amasamalidwira akapita kuchipatala kukalandira chithandizo panthawi yochira. Zokambiranazi ndizachinsinsi ndipo ine ndi omwe akundiphunzitsa ndiokhawo amene titakhale ndi mpata oziona. Pamapeto akafukufukuyu zonsezi zidzaonongedwa ndicholinga chakuti ena asazione.

PHINDU LA KAFUKUFUKU

Pakutenga nawo mbali mukafukufukuyu muthandiza kuonjezera nzeru za momwe amai ayenera kusamalidwira kuchipatala kokachira mofuna kulemekeza umunthu wao.

Muli ndiufulu osatenga nawo mbali mukafukufukuyu komanso kusayankha funso limene simukufuna kutero. Muthanso kulekezera panjira ngati mutaona kuti simukwanitsa kupitiliza zokambiranazi.

Mutha kufunsa mafunso ngati pali pena pomwe simunamvetse. Mulinso omasuka kundifunsa ngakhale titamaliza zokambiranazi kudzela pa lamya iyi: 0888857679.

KUVOMEREZA KUTENGA NAWO MBALI PAKAFUKUFUKU

Ndikuvomereza kuti ndawerenga/andiwerengera zonse zokhudzana ndikafukufukuyu komanso mafunso omwe ndinali nawo ayankhidwa mokwanira. Choncho ndikuvomera kutenga nawo mbali mosakakamizidwa mukafukufuku ameneyu.

Sayini ya olowa nao mukafukufuku

Tsiku

Saini ya otenga chilolezo

Tsiku

Appendix 2: Questionnaire for the postnatal mothers

English version

WOMENS' PERCEPTION OF CARE THEY RECEIVE DURING LABOUR AND DELIVERY

PART ONE: DEMOGRAPHIC CHARATERISTICS.

1. **Age:……..**

1□< 15years **2**□15-19years **3**□20-29years **4**□30-39years 5□40-49years **6**□>49years

2. **Ethnicity:** 1□Chewa 2□Lomwe **3**□Sena **4**□Yao **5**□Tumbuka **6**□others specify….....
3. **Religion:** 1□Christian **2**□Muslim **3**□Others Specify……
4. **Marital status:** 1□single **2**□Married **3**□widow **4**□Others specify……..
5. **Number of children**: ……

1□0 **2**□1 **3**□2 **4**□3 **5**□4 **6**□>4

6. **Education level**:……..

1□≤standard 8 2□≤form 4 **3**□>form 4

7. **Local language:** 1□Chichewa **2**□Yao **3**□Sena 4□tumbuka 5□Others specify……..
8. **Occupation**:…….
9. **Time of admission in labor ward**: ……..
10. **Time of delivery**: …….

PART TWO: THE PHYSICAL ENVIRONMENT

11. During this hospital stay, did you labor and deliver in a separate room or in a room with other women?

1□In a separate room 2□with other women → ***if 1 go to question 13***

12. If in a room with others, were your bed screened?

1□Screened 2□not screened 3□ partly screened.

13. During this hospital stay, was history taking done in a private room or in the presence of others?

1□Private room 2□in the presence of others 3□ partly screened place

14. What about other personal questions or communication, was it done in a private room or in the presence of others?

1□Private room 2□in the presence of others 3□ partly screened place

15. During this hospital stay, were you provided with functioning bathroom, toilet and washing area?

Bathroom 1□functioning 2□not functioning 3□ functioning but dirty 4□did not visit the bathroom 5□there are no bathrooms

Toilet 1□functioning 2□not functioning 3□ functioning but dirty 4□did not visit the toilet 5□there are no toilets

Washing area 1□functioning 2□not functioning 3□ functioning but dirty 4□did not visit the washing area 5□there is no washing area

16. During this hospital stay, how many times was your room cleaned?

1□Zero 2□once 3□twice 4□thrice 5□more than three times 6□did not see them cleaning.

17. During this hospital stay, how many times was your bathroom cleaned?

1□Zero 2□once 3□twice 4□thrice 5□more than three times 6□did not see them cleaning.

PART THREE: ORGANISATION CULTURE

18. During this hospital stay, upon arriving at the point of entry to the facility, were you escorted to the labor ward by any staff member?

1□Escorted 2□not escorted → ***if 1 go to question 20***

19. During this hospital stay, upon arriving at the point of entry to the facility, were you directed to the labor ward?

1□directed 2□not directed.

20. During this hospital stay, did staff wear identification badges?

1□Yes all 2□No 3□Yes, some health workers

21. During this hospital stay, did staff introduce themselves to you by name?

1□Yes all 2□No 3□Yes, some health workers

22. During this hospital stay, after the first interaction with a staff member were you greeted by name in the subsequent interactions?

1□Yes by all 2□No 3□Yes by some health workers

If no, elaborate:……

23. During this hospital stay, were the staff members using the language you were able to understand?

1□Yes all 2□No 3□Yes, some health workers

If no, elaborate: ……

24. During this hospital stay, were you allowed to have a companion during labor and delivery?

1□Yes 2□No

If yes, who was the companion?.....

25. During this hospital stay, were you told on how and where you can ask for assistance?

1□Yes 2□No

26. During this hospital stay, did you see any poster or told on:

a. Where you can complain if you have problems 1□Yes 2□No
b. Your rights and responsibilities 1□Yes 2□No
c. Price of services 1□Yes 2□No

PART FOUR: THE WAY CARE ACTIVITIES ARE CARRIED OUT

27. During this hospital stay, were you asked about your needs and well being?

1□Never 2□at times 3□ Always

28. During this hospital stay, did the nurse/midwife explain all procedures before carrying them out?

1□Never 2□at times 3□ Always

29. During this hospital stay, were treatment alternatives explained to you by the nurse/midwife?

1□Never 2□at times 3□ Always

30. During this hospital stay, were your opinions sought?

1□Never 2□at times 3□ always ***if never go to question 32***

31. During this hospital stay, were your choices taken into consideration by the nurse/midwife?

1□Never 2□at times 3□Always

32. During this hospital stay, were your bed covered with linen?

1□Never 2□at times 3□ Always

33. During this hospital stay, were you covered with linen?

1□Never 2□at times 3□ Always

34. During this hospital stay, were you not exposed unnecessarily?

1□Never 2□Sometimes 3□Always

35. Did you use hospital linen or linen from your home?

1□Linen from home 2□Hospital linen.

36. During this hospital stay, did staff use low tone in communication?

1□Low tone 2□high tone

37. During this hospital stay, did staff shout when communicating with you?

1□Shouting 2□ Speaking as if they were not interested in talking to me3□ No

PART FIVE: ATTITUDES AND BEHAVIOUR OF MIDWIVES

38. During this hospital stay, how often did nurse/midwives treat you with courtesy and respect?

1□Never 2□Sometimes 3□Always

If never or sometimes, elaborate: ……..

39. During this hospital stay, how often did nurse/midwives listen carefully to you?

1□Never 2□Sometimes 3□Always

If never or sometimes, elaborate: ……..

40. During this hospital stay, how often did nurse/midwives explain things in a way you could understand?

1□Never 2□Sometimes 3□Always

If never or sometimes, elaborate: ……..

41. During this hospital stay, when you called for assistance, how often did you get help as soon as you wanted it?

1□Never 2□Sometimes 3□ Always 4□I never called for help

If never or sometimes, elaborate: ……..

42. During this hospital stay, did you ask for help from nurse/midwives in getting to the bathroom?

1□Yes 2□No ***If No, Go to Question 44***

43. How often did you get help in getting to the bathroom as soon as you wanted?

1□Never 2□Sometimes 3□ Always

If never or sometimes, elaborate: ……..

44. During this hospital stay, did you ask for help from nurse/midwives in using a bedpan?

1□Yes 2□No ***If No, Go to Question 46***

45. How often did you get help in using a bedpan as soon as you wanted?

1□Never 2□Sometimes 3□ Always

If never or sometimes, elaborate: ……..

46. Did you not ask for bathroom or bedpan assistance because you did not want to use the bathroom or bedpan or you had other reasons?

1□did not want to use the bathroom/bedpan 2□Had other reasons

If other reason, explain: ……..

47. During this hospital stay, were you asked to pay for treatment or any service rendered to you?

1□Yes 2□No

If yes, for what and how much?.....

48. During this hospital stay, were you asked to bring anything to give to the nurse/midwife as a token of thanks?

1□Yes 2□No

If yes, specify: ……..

49. During this hospital stay, were you slapped or pinched by the health provider?

Slapped 1□Yes 2□No

Pinched 1□Yes 2□No

50. During this hospital stay, were you shouted at by the members of staff?

1□Yes 2□No

51. During this hospital stay, were you asked to:

a. Clean the delivery bed you used 1□Yes 2□No
b. Wash the hospital linen you used 1□Yes 2□No
c. Mop the floor you soiled 1□Yes 2□No

PART SIX: WOMENS VIEWS ON DIGNITY AND SUGGESTIONS FOR IMPROVEMENT

52. Would you recommend this hospital to your friends and family?

1□Definitely no 2□Probably no 3□Probably yes 4□Definitely yes

53. Why or why not?

……

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……

……

54. What went well with your care?

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55. What did not go well with your care?

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56. What do you want the hospital to keep/maintain?

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57. What do you want the hospital to change?

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58. What do you understand by dignity?

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59. How would you like to be treated with dignity?

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60. In what situations did you feel that you were treated with dignity?

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61. In what situations did you feel that you were not treated with dignity?

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62. According to you, what do you think are the reasons why some women are not treated with dignity during labor and delivery?

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63. Do you have any more comments or questions?

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…….....

Chichewa version

Mafunso Kwa A Mayi Omwe Angochembeza Kumene
Ndemanga za amai Pa Chisamaliro chomwe analandira nthawi imene amakachira

GAWO LOYAMBA: MBIRI YANU

1. Muli ndi zaka zingati? .....
   (1□<15 2□15-19 3□20-29 4□30-39 5□40-49 6□>49)

2. Mtundu wanu ndi uti? (mtundu wamakolo) 1□ achewa 2□ alomwe **3**□asena
   4□ ayao **5**□ atumbuka **6**□wina (tchulani)….....

3. Chipembezo chanu ndi chiti?: 1□ chikhirisitu **2**□ chisilamu **3**□china
   (tchulani)….

4. Muli pa banja?: 1□ Osakwatiwa **2**□okwatiwa **3**□wamasiye **4**□Zina
   (tchulani)……

5. Muli ndi ana angati?: ……
   (1□0 2□1 3□2 4□3 5□4 6□>4)

6. Maphunziro munafika nawo pati?: ……...
   (1□≤standard 8 2□≤form 4 3□> form 4)

7. Mumayankhula chiyankhulo chanji?: 1□Chichewa **2**□ Chiyao **3**□ Chisena 4□
   Chitumbuka 5□ China (tchulani)……

8. Mumagwira ntchito yanji?……

(1□working 2□not working)

9. Munafika muno nthawi zanji? (Nthawi yomwe anakugonekani ku leba wodi)
   ……..

10. Nanga mwana anabadwa nthawi zanji? ……..

GAWO LACHIWIRI: MCHIPINDA MOCHILIRA

11. Kodi nthawi yomwe matenda anu anayamba komanso nthawi yomwe mumachira, munali muchipinda chanokha kapena munali m'chipinda chomwe munali amai ena?

    1□ Ndinali muchipinda chandekha 2□ Muchipinda munali amai ena

    → ***Ngati anali muchipinda chaokha, pitani kufunso 11***

12. kodi pakama pomwe munagona, anatchingapo kuti anthu asaone zomwe zikuchitika? *(Ngati munali muchipinda chomwe munali amai ena*).

    1□ Panatchingidwa 2□ Sipanatchingidwe 3□ Panatchingidwa mosakwanira

13. Nanga nthawi yomwe amakufunsani mafunso okhudza mbiri yanu, anakufunsani muli mchipinda chanokha kapena pali anthu ena omwe amamvera zomwe mumakambirana?
    1□ Ndinali mchipinda chandekha 2□ Panali anthu ena 3□ Ndinali chobisika pang'ono

14. Nanga mafunso ena ndi ena okhudza inu komanso zokambirana zina ndi zina, amakufunsani panokha kapena pagulu la anthu ena omwe amamva nao zokambirana zanu?

    1□ Ndinali mchipinda chandekha 2□ Panali anthu ena 3□ Ndinali mchipinda chobisika pang'ono

15. Kodi nthawi yomwe mwakhala pachipatala pano, chimbuzi, bafa komanso malo ochapila zimagwira ntchito?

Bafa: 1□ Limagwira ntchito 2□Linali loonongeka 3□ limagwira ntchito koma munali mwa umve kwambiri 4 □Sindinafikeko 5 □palibe bafa

Chimbudzi: 1□ Chimagwira ntchito 2□Chinali choonongeka 3□Chimagwira ntchito koma chinali cha umve kwambiri 4□Sindinafikeko 5□ Palibe Chimbudzi

Malo ochapila zovala: 1□Amagwira ntchito 2□Anali oonongeka 3□ Amagwira ntchito koma anali a umve kwambiri 4□Sindinafikeko 5□kulibe malo ochapila

16. Kodi nthawi yomwe mwakhala mchipatala muno, mchipinda chanu munakolopedwa kangati?

1□simunakolopedwe 2□Kamodzi 3□ Kawiri 4□ Katatu 5□ Koposera katatu 6□Sindinawaone akukolopa

17. Kodi nthawi yomwe mwakhala mchipinda muno, ku bafa kunakolopedwa kangati?

1□simunakolopedwe 2□Kamodzi 3□ Kawiri 4□ Katatu 5□ Koposera katatu 6□Sindinawaone akukolopa

GAWO LACHITATU: CHIKAHALIDWE CHAPACHIPATALA

18. Kodi nthawi yomwe mumabwera kuchipatala kuno kudzachira, mutafika polowera mkati mwachipatala, ogwira ntchito kuchipatala kuno anakuperekezani kuchipinda chochilila (ku leba)?

1□Anandiperekeza 2□ Sanandiperekeze

→ Ngati anaperekezedwa, pitani ku funso 20

19. Nanga ogwira ntchito pachipatala pano anakulozerani ku chipinda chochilira? *(Ngati sanakuperekezeni*)

1□Anandilozera 2□ Sanandilozere.

20. Kodi nthawi yomwe mwakhala mchipatala muno, ogwira ntchito amavala zizindikiro zosonyeza maina awo

    1□ Onse amavala 2□ Samavala 3□ Ena amavala, ena ayi

21. Kodi nthawi yomwe mwakhala mchipatala muno, ogwira ntchito, amakuudzani dzina lao musanayambe kukambirana?

    1□ Onse amandiudza 2□ Samandiudza 3□ Ena amandiudza, ena ayi

22. Kodi mutawadziwitsa ogwira ntchito mchipatala muno dzina lanu, iwo amakutchulani dzina lanu akamakuyankhulani?

    1□ Eya, onse amanditchula dzina 2□ Samanditchula dzina 3□ Ena amanditchula, ena ayi

    Ngati samakutchulani, fotokozani:……

23. Kodi nthawi yomwe mwakhala mchipatala muno, chiyankhulo chomwe ogwira ntchito pachipatala pano amayankhula mumachimva mosavuta

    1□Eya, ndimamva mosavuta 2□ Ayi 3□ Ena ndimawamva, ena ayi.

    Ngati simumamva, fotokozani ……

24. Kodi nthawi yomwe mumakachira komanso nthawi yomwe mumachira, munaloledwa kukhala ndi okudikirirani?

    1□Eya 2□Ayi

    Ngati munaloledwa, anakudikirirani ndani?.....

25. Kodi nthawi yomwe mwakhala mchipatala muno, ogwira ntchito anakufotokozerani komwe mungafunse mutafuna thandizo la mtundu wina uli wonse?

    1□Eya 2□Ayi

26. Kodi nthawi yomwe mwakhala mchipatala muno, munaonako chidziwitso chokufotokozerani ndondomeko izi, kapena anakufotokozerani:

    Komwe mungakadandaule ngati mutakumana ndizovuta

    1□Eya 2□Ayi

    Ufulu wanu komanso udindo omwe muli nawo

1□ Eya 2□ Ayi

Mtengo wa zithandizo zosiyanasiyana zomwe zimaperekedwa pachipatala pano

1□ Eya 2□ Ayi

GAWO LACHINAYI: M'MENE OGWIRA NTCHITO ANAKUSAMALIRANI

27. Kodi nthawi yomwe mwakhala mchipatala muno, ogwira ntchito anakufunsaniko zaumoyo wanu komanso zomwe inu mukufuna?

    1□Sanandifunseko 2□ Nthawi zina amafunsa 3□ Amandifunsa nthawi zonse

28. Nthawi yomwe mwakhala mchipatala muno, anamwino/azamba amakufotokozerani chomwe akufuna kuchita asanachite china chilichonse pa inu?

    1□Samandifotokozera 2□Pena amafotokokoza pena ayi 3□ Amafotokoza nthawi zonse

29. Kodi nthawi yomwe mwakhala mchipatala muno, anamwino kapena azamba amakufotokozerani pakakhala kusintha kwa thandizo lomwe mukulandira?

    1□Sanandifotokozereko 2□Pena amafotokoza, pena ayi 3□Amafotokoza nthawi zonse

30. Kodi nthawi yomwe mwakhala mchipatala muno, ogwira ntchito amafunsa maganizo anu pa thandizo lomwe mukulandira?

1□Sanandifunseko 2□Pena amandifunsa pena ayi 3□ □Amandifunsa nthawi zones ***ngati sanafunseko pitani ku funso 32***

31. Kodi anamwino kapena azamba amalingalirako zokhumba zanu popereka thandizo nthawi yomwe mwakhala nchipatala muno?

    1□Ayi 2□Pena amalingalira pena ayi 3□ Amalingalira nthawi zonse

32. Kodi pakama panu pamayalidwa ndi zofunda nthawi yomwe mwakhala mchipatala muno?

1□Ayi 2□Pena amayala pena ayi 3□ Pamayalidwa nthawi zonse

33. Kodi nthawi yomwe munali mchipatala muno, amakufunditsani zofunda nthawi zones?
    1□Ayi 2□Pena amatifundisa pena ayi 3□amatifundisa nthawi zonse

34. Kodi nthawi yomwe mwakhala mchipatala muno, ogwira ntchito samakuvundukulani vundukulani pena popanda chifukwa cheni cheni?
    1□Ayi 2□Nthawi zina 3□ Amandivundukula nthawi zonse

35. Nanga zofundazi zinali zanu kapena zachipatala?
    1□zathu 2□zachipatala.
36. Nanga ogwira ntchito mchipatala muno, amakuyankhulani pang'onopang'ono kuti anthu ena asamve nawo zomwe mukuyankhulanazo kapena amakuwa akamakuyankhulani?

    1□ Amayankhula pang'ono pang'ono 2□Amakuwa
37. Nanga amayankhula mokalipa kapena moonesa kuti alibe nanu ntchito?
    1□Mokalipa 2 □moonesa kuti alibe nane ntchito 3□Samakalipa amayankhula bwinobwino

GAWO LACHISANU: KHALIDWE LA ANTHU OGWIRA NTCHITO PACHIPATALA

38. Pa nthawi yomwe munali mchipatala muno, ndi kangati komwe a namwino kapena azamba anakuthandizani mwa ulemu?
    1□Palibe 2□Nthawi zina 3□Nthawi zonse
    Ngati palibe, fotokozani ……..

39. Nanga nthawi yomwe mwakhala mchipatala muno, ndikangati komwe a namwino kapena azamba anamvetsera mwachidwi inu mukuwayankhula?
    1□Palibe 2□Nthawi zina 3□Nthawi zonse
    Ngati palibe, fotokozani ……..

40. Nanga ndikangati komwe a namwino kapena azamba anakufotokozerani mwatsatanetsatane komanso momveka bwino?

    1□Palibe 2□Nthawi zina 3□Nthawi zonse

    Ngati palibe, fotokozani ……..

41. Kodi nthawi yomwe munali mchipatala muno, anamwino kapena azamba amakuthandizana mwachangu mukapempha thandizo?

    1□Ayi 2□Nthawi zina 3□Nthawi zonse 4□ Sindinapempheko thandizo

    Ngati ayi, kapena nthawi zina, fotokozani ……

42. Kodi nthawi yomwe mwakhala mchipatala muno, munawapemphako anamwino kapena azamba kuti akuperekezeni ku bafa?

    1□Eya 2□Ayi ***Ngati ayi, dumphani ndipo mupite funso 44***

43. Kodi ndi kangati komwe anamwino kapena azamba anakuperekezani ku bafa mutawapempha?

    1□Palibe 2□Nthawi zina 3□Nthawi zonse

Ngati palibe kapena nthawi zonse, fotokozani……

44. Kodi nthawi yomwe munali mchipatala muno, munawapemphako ogwira ntchito kuti akubweretsereni mozithandizira pamalo pomwe munagona

    1□Eya 2□Ayi ***Ngati ayi, pitani funso 46***

45. Ndikangati komwe ogwira ntchito anakubweretserani mozithandizira mutawapempha?

    1□Palibe 2□Nthawi zina 3□ Nthawi zonse

    Ngati palibe kapena nthawi zina, fotokozani: ……..

46. Kodi simunawapemphe ogwira ntchito kuchipatala kuti akubweretsereni mozithandizira kapena kuti akupelekezeni ku bafa chifukwa chokuti simumafuna chithandizo kapena panali zifukwa zina zomwe zimakuletsani kutero?

    1□sindimafuna thandizo 2□panali zifukwa zina.

    Ngati panali zifukwa zina, fotokozani: ……
……
……..

47. Kodi munawuzidwako kuti mulipire chifukwa cha thandizo lomwe mwalandira ndi ogwira ntchito mchipatala muno panthawi yomwe mwakhala mchipatala muno?

    1□Eya 2□Ayi

    Ngati munauzidwa, ndithandizo lanji lomwe anati mulipire ndipo ndalama zingati?.....

48. Nanga munauzidwako kuti mubweretse kena kake kwa anamwino kapena azamba kusonyeza kuthokoza kwanu chifukwa cha thandizo lomwe mwalandira mchipatala muno?

    1□Eya 2□Ayi

    Ngati eya, Fotokozani ……..

49. Nthawi yomwe mwakhala mchipatala muno, munamemyedwako kapena kutsinidwa ndi ogwira ntchito?

    Kumenyedwa 1 □Eya 2□Ayi

    Kutsinidwa 1 □Eya 2□Ayi

50. Nanga ogwira ntchito anakulalatilaniko kapena kukukalipirani nthawi yomwe munali mchipatala muno?

    1□Eya 2□Ayi

51. Nanga munapemphedwapo kapena kuuzidwa kuti mukonze pa kama pomwe munagona nthawi yomwe mumachira, muchape zachipatala zomwe munaipisira komanso mukolope pansi pomwe munaipitsa?

    1. Kuti mukonze pa kama 1□Eya 2□Ayi

2. Muchape zachipatala zomwe munaipisira 1□Eya 2□Ayi
3. Mukolope pansi pomwe munaipisira 1□Eya 2□Ayi

GAWO LACHISANU NDI CHIMODZI: MAGANIZO A MAI PA NKHANI YOTHANDIZIDWA MWA UMUNTHU KOMANSO PA ZOMWE ZIKUYENERA KUSINTHIDWA KUTI NTCHITO ZAPACHIPATALA ZIPITE PATSOGOLO

52. Kodi mungamulimbikitse nzanu kapena mbale wanu kuti azachilire pachipatala chino?

1□Sindingamulimbikitse mpang'ono pomwe 2□ Mwina ayi 3□ Mwina ndikhonza kumulimbikitsa 4□Eya, ndikhonza kumulimbikitsa

53. Chifukwa chiyani mungamulimbikitse kapena simungamulimbikitse?

……`……..…
……
……..…
……

54. Ndichiyani chomwe munganene kuti chinayenda bwino nthawi yomwe mumasamalidwa pachipatala pano?

……
……
……
……

55. Nanga ndichiyani chomwe sichinayende bwino?

……
……
……
……

56. Ndichiyani chomwe mungafune kuti chipatala chino chipitilize?

……
……
……
……

57. Nanga ndichiyani chomwe mungafune kuti chisinthe?

……

……

……

……

58. Kodi mau oti “umunthu” kwa inu amathandauza chiyani?

……

……

……

……

59. Kodi mungafune kuti akuchipatala azikuthandizani bwanji kuti muone kuti akusungilani umunthu wanu pamene mukuthandizidwa?

……

……

……

……

60. Kodi nthawi yomwe mumathandidzidwa mchipatala muno, ndi nthawi iti yomwe munaona kuti anakuthandizani mwa umunthu.

……

……

……

……

61. Nanga ndi nthawi iti yomwe munaona kuti simunathandizidwe mwa umunthu?

    ……

    ……

    ……

    ……

62. Nanga mukuona kuti chimachitisa ndi chani kuti odwala asamathandizidwe mwa umunthu?

    ……

    ……

    ……

    ……

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……

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……

……

63. Muli ndi mafunso kapena ndemanga?

……

……

……

……

Appendix 3: Questionnaire for the Nurse/midwives

FACTORS THAT PROMOTE OR COMPROMISE DIGNIFIED CARE DURING SERVICE DELIVERY: MIDWIVES POINT OF VIEW.

PART ONE: DEMOGRAPHIC CHARACTERISTICS.

1. Sex: □Male □Female
2. Age: □< 20years □20-30years □30-40years □40-50years □>50years
3. Ethnicity: □Chewa □Lomwe □Sena □Yao □Tumbuka □Ngoni □others specify….....
4. Religion: □Christian □Moslem □Others specify……
5. Marital status: □single □Married □widowed □Others specify……..
6. Number of children: □0 □1 □2 □3 □4 □>4
7. Education level: □Certificate □Diploma □Degree
8. Local language: □Chichewa □Yao □Sena □tumbuka □Others specify……..

PART TWO: GENERAL INFORMATION

9. Where did you qualify as a nurse/midwife?
   □University of Malawi □Malawi college of Health Sciences□Christian Health Association of Malawi (CHAM) facility □Others specify…….
10. In which year did you qualify as a nurse?
    .....
11. How many years have you worked as a nurse/midwife?
    .....
12. In your own words, what do you understand by dignity?
    ……
    ……
    ……
13. A) What do you understand by dignified care? Can you give examples?
    .....
    .....
    B) What about undignified care? Can you give examples?

……

……

……

……

……..……..

14. During your initial training to become a nurse/midwife were you taught about dignity?

1□**Yes** 2□**No** 3□**Dont know**

15. How much did this initial training influence your understanding of dignity?

1□A lot **2□somewhat** **3□not very much** **4□not at all**

5□don't know

16. How much did this initial training influence your professional practice?

1□A lot **2□somewhat** **3□not very much** **4□not at all**

5□don't know

17. Have you ever had an in service training on dignity?

1□**Yes** 2□**No**

18. How much did this in service training influence your understanding of dignity?

1□A lot **2□somewhat** **3□not very much** **4□not at all**

5□don't know

19. How much did this in service training influence your professional practice?

1□A lot **2□somewhat** **3□not very much** **4□not at all**

5□don't know

PART THREE: PHYSICAL ENVIRONMENT

20. Looking at the physical environment where you work, are there any areas where dignity is:

    a. Exercised?

……

……

    b. Compromised?

……

……

21. What things about your physical environment need to change to help you maintain, promote and deliver dignified care in a more effective way?

……

……

……

PART FOUR ORGANISATION CULTURE

22. Are there things within the organization (MOH) that help you to maintain, promote and deliver dignified care?

……

……

……

23. Are there things within the organization that prevent you from maintaining, promoting and delivering dignified care?

……

……

……

24. Can you describe any initiatives in this area of practice that promotes the dignity of :
    a. Patients?

    .....

    ……

    b. Staff?

    ……

    ……

25. Are there things within the organization that need to change to help you maintain, promote and deliver dignified care more effectively?

……

……

……

PART FIVE: CARE ACTIVITIES

26. Please describe a care activity you undertake with your patients, that because of the type of the procedure or condition is mostly likely to lead to loss of dignity? (procedures you think that patients cannot be treated with dignity)

    ……

    ……

    ……

27. Now please describe the steps you take to minimize the loss of dignity with the particular care activity mentioned above?

    ……

    ……

    ……

28. What do you understand by:

    Confidentiality:……

    ……

    ……..

    Privacy…….

    ……

    ……..

    Informed choice ……

    ……

    ……

    Informed consent ……

    ……..……

    ……..

    Autonomy ……

    …….

    ……..

    ……..……

    Respect and equal treatment …….

……

……

……

29. How do you practice:

Confidentiality…….....

……

……

Privacy……..

……

…….

Informed choice ……

……

……

Informed consent ……..……..……..

……

……

Autonomy …….

……

……

Respect and equal treatment …….

……

……

……

30. Do nurse/midwives listen and respect women choices and options regarding birth?

1□Always 2□sometimes 3□Not at all

PART SIX: ATTITUDES AND BEHAVIOUR

31. Thinking about your practice, how would you rate the dignity of care you give to your patients?

1□Excellent 2□very good 3□good

4□neither good nor bad 5□bad 6□very bad

32. Do you have enough time to devote to the dignity of your patients as part of your daily routine?

1□Always **2□sometimes** **3□never**

33. Do you ever feel upset or distressed because you are unable to give the kind of dignified care you know you should?

1□Always **2□Sometimes** **3□Never**

34. Do you know any specific types of patients that have been treated differently (in terms of dignified care)?

……

……

……

35. According to you, what do you think are the reasons why some women are not treated with dignity?

……

……

……

……

……

……

……

36. Do you have any comments or suggestions?

……

……

……..

Appendix 4: Discussion guide.

English version

FOCUS GROUP DISCUSSION GUIDE FOR MEN AND WOMEN

1. What do you understand by dignity?

(Probe on: the social concept and human rights concept of dignity)

2. Do midwives at the hospital treat you with dignity?

(Probe: Explain how you are treated with dignity and how you are not treated with dignity when you visit the hospital)

3. Explain how you would want to be treated with dignity by the hospital. *(Probe on the physical environment and the processes that are involved in care provision)*

4. What do you like and dislike about the treatment/care you receive from the hospital?

5. How do you look at the care women receive during labor and delivery at the Hospital?

(*Probe on whether they are treated with dignity by nurses/midwives or not. Let them explain also how they look at the physical environment and the processes involved in labor and delivery services)*

Chichewa Version

DIGNITY IN MATERNAL HEALTH SERVICE DELIVERY INTERVIEW GUIDES

A. MAFUNSO KWA MAGULU A AZIBAMBO

1. Kodi mawu woti “umunthu” amatanthauza chiyani kwa inu?
   (Funsisitsani pa izi: Nanga pakati panu, mukati munthu uyu ali ndi umunthu m’matanthauza chiyani? Perekani zitsanzo! Nanga pa nkhani za ufulu a chibadidwe,umunthu umatanthauza chiyani? Perekani zitsanzo)

2. Kodi ogwira ntchito za umoyo kuchipatala amakusamalirani mwa umunthu pamene mukulandira chithandizo ku chipatala? *(Longosolani m’mene amakusamaliririrani mwa umunthu ndi m’mene samakusamalirani mwa umunthu).*

3. Longosolani m’mene m’mafunira kuti anthu a zaumoyo akuchipatala azikusamalilirani mwa umunthu. *(Perekani zitsanzo za m’mene mukufuna kuti azikusamalilirani mwa umunthu. Mukufuna kuti kuchipatala kuziwoneka bwanji kapena kuti kuzipezeka zinthu ziti kuti umunthu wanu ulemekezedwe pamene mukulandira chithandizo cha kuchipatala. Azikulandirani ndi kukusamalirani bwanji?)*

4. Ndi zinthu ziti zimene m’masangalala nazo kapena simusangalala nazo pa chisamaliro chimene m’malandira ku chipatala? *(Perekani zitsanzo za zinthu zimene m’masangalala nazo ndi zinthu zimene simusangalala nazo pa chisamaliro cha kuchipatala).*

5. Kodi chisamaliro chimene azimayi amalandira kuchipatala pa nthawi yomwe ali ku chiyembekezo ndi pa nthawi yokachila m’machiwona bwanji? *(Longosolani m’mene azimayi amasamaliridwa mwa umunthu kapena ayi ndi anamwino kapena azamba amene amagwira ntchito ku malo a chiyembekezo ndi ochilira. Longosolaninso m’mene m’mawaonera malo ochilira/woberekerako).*

6. *Perekani ndemenga ina liliyonse pa mfundo zomwe takambiranazi.*

B. MAFUNSO KWA MAGULU A AZIMAYI

1. Kodi mawu woti “umunthu” amatanthauza chiyani kwa inu?
   (Funsisitsani pa izi: Nanga pakati panu, mukati munthu uyu ali ndi umunthu m’matanthauza chiyani? Perekani zitsanzo! Nanga pa nkhani za ufulu a chibadidwe,umunthu umatanthauza chiyani kwa inu? Perekani zitsanzo)

2. Kodi ogwira ntchito za umoyo kuchipatala amakusamalirani inu azimayi mwa umunthu? *(Longosolani m’mene amakusamaliririrani mwa umunthu ndi m’mene samakusamalirani mwa umunthu).*

3. Longosolani m’mene mukufunira kuti anthu a zaumoyo akuchipatala azikusamalilirani mwa umunthu. *(Perekani zitsanzo za m’mene mukufuna kuti azikusamalilirani mwa umunthu. Nanga mukufuna kuti kuchipatala kuziwoneka bwanji kapena kuti kuzipezeka zinthu ziti kuti umunthu wanu uzilemekezedwa pamene mukulandira chithandizo cha kuchipatala. Mukufuna kuti anthu ogwira ntchito ku chipatala azikulandirani ndi kukusamalirani bwanji?)*

4. Ndi zinthu ziti zimene inu amayi m’masangalala nazo kapena kukhumudwa nazo pamene mukulandira chisamaliro cha ku chipatala? *(Perekani zitsanzo za zinthu zimene m’masangalala nazo ndi zinthu zimene simusangalala nazo pa chisamaliro cha kuchipatala).*

5. Nanga chisamaliro chimene inu azimayi m’malandira kuchipatala pa nthawi yomwe muli ku chiyemebzo ndi pa nthawi yomwe mukukachila m’machiwona bwanji? *(Longosolani m’mene anamwino ndi azamba amakusamalirani mwa umunthu ndi m’mene sakusamalilirani mwa umunthu. Nanga ku malo amene m’mayembekezerako kuchila ndi ku malo wochilira m’makuwona bwanji? Longosolani za ukhundo kapena nyansi za ku malowa.*

6. *Perekani ndemenga ina liliyonse pa mfundo zomwe takambiranazi.*

Appendix 5: Letter from the department

UNIVERSITY OF OSLO

INSTITUTE OF HEALTH AND SOCIETY
Department of General Practice and Community Medicine
Section for International Health
P.O. Box 1130 Blindern
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June 21st, 2010

To Whom It May Concern

Regarding M.Phil student Lucy Chigwenembe's fieldwork in Malawi

Lucy Chigwenembe is enrolled in the Master of Philosophy programme International Community Health at the Department of General Practice and Community Medicine, Faculty of Medicine, University of Oslo in Norway.

The first year of the master programme is classroom-based with lectures, seminars and workshops. The second year consists of the student's independent fieldwork which is a part of their Master thesis, and the Master thesis's writing process. The fieldwork is to take place in Malawi, and begins in summer 2010 and last until the end of December 2010.

The Master of Philosophy project Lucy Chigwenemebe will be conducting is approved by the Section of International Health at the Department of General Practice and Community Medicine, Faculty of Medicine, University of Oslo.

The research protocol for the Master of Philosophy project titled "Human dignity in Maternal Health Service delivery" has been approved by the project supervisor professor Johanne Sundby at the Section for International Health, Department of General Practice and Community Medicine.

Yours sincerely

Gunnar Bjune
Professor
Head of the Section for International Health

Line Løw
Programme coordinator
Section for International Health

M.PHIL PROGRAMME
INTERNATIONAL COMMUNITY HEALTH
FACULTY OF MEDICINE
UNIVERSITY OF OSLO, NORWAY

Faculty of Medicine
University of Oslo

Appendix 6: Permission letter from QECH.

Telephone: (265) 01 874 333 / 677 333
Facsimile: (265) 01 876928
Email: queenshosp@globemw.net

All communications should be addressed to:
The Hospital Director

In reply please quote **No.**

QUEEN ELIZABETH CENTRAL HOSPITAL
P.O. BOX 95
BLANTYRE
MALAWI

Ref No. QE/10 22nd July, 2010

Lucy Chigwenembe
Institute of Health and Society
Department of General Practice and Community Medicine
Section for International Health
P.O. Box 1130 Blindern
N-0317 Oslo
Norway

Dear Madam

PERMISSION TO CONDUCT RESEARCH AT QUEEN ELIZABETH CENTRAL HOSPITAL ON "HUMAN DIGNITY IN MATERNAL HEALTH SERVICES DELIVERY"

The above refers.

I am pleased to inform you that your request to conduct research at QECH has been accepted.

We will appreciate if a copy of your findings is shared with the hospital.

All the best in your studies.

Yours faithfully,

T.N. Soko
CHIEF NURSING OFFICER
For: HOSPITAL DIRECTOR

Appendix 7: Permission letter from Chiradzulu District Health Office.

Ref. No. CH/A/
All correspondence to:
The District Health Officer
Tel: 01 693225/220
Fax: 01693271

District Hospital
P.O. Box 21
CHIRADZULU

20th July, 2010

Dear Sir/Madam

RE: AUTHORITY TO CONDUCT A STUDY IN CHIRADZULU DISTRICT

This is to authorize LUCY CHIGWENEMBE, a Masters Degree student from the University of Oslo, Institute of Health and Society to conduct a study in Chiradzulu district.

Please provide her with the necessary support for her to achieve the desired objective

Yours truly

CHIRADZULU DISTRICT HOSPIT L
DISTRICT HEALTH OFFICER
2010 -07- 21
P.O. BOX 21, CHIRADZULU

DR. M.E. CHIUME
DISTRICT HEALTH OFFICER

Appendix 8: Ethical approval

Telephone: + 265 789 400
Facsimile: + 265 789 431
e-mail doccentre@malawi.net
All Communications should be addressed to:
The Secretary for Health and Population

In reply please quote No. MED/4/36c

MINISTRY OF HEALTH
P.O. BOX 30377
LILONGWE 3
MALAWI

3 August 2010

Lucy Chigwenembe
University of Oslo

Dear Sir/Madam,

RE: **Protocol #758: Cross sectional clinical survey on factors that promote or compromise dignity in maternal health service delivery: Perspectives of women and midwives from Southern Malawi**

Thank you for the above titled proposal that you submitted to the National Health Sciences Research Committee (NHSRC) for review. Please be advised that the NHSRC has **reviewed** and **approved** your application to conduct the above titled study.

- **APPROVAL NUMBER : NHSRC #758**
  The above details should be used on all correspondence, consent forms and documents as appropriate.
- **APPROVAL DATE** : 03/**08/2010**
- **EXPIRATION DATE** :This approval expires on 02/**08/2011**
  After this date, this project may only continue upon renewal. For purposes of renewal, a progress report on a standard form obtainable from the NHSRC secretariat should be submitted one month before the expiration date for continuing review.
- **SERIOUS ADVERSE EVENT REPORTING** :All serious problems having to do with subject safety must be reported to the National Health Sciences Research Committee within 10 working days using standard forms obtainable from the NHSRC Secretariat.
- **MODIFICATIONS**: Prior NHSRC approval using standard forms obtainable from the NHSRC Secretariat is required before implementing any changes in the Protocol (including changes in the consent documents). You may not use any other consent documents besides those approved by the NHSRC.
- **TERMINATION OF STUDY**: On termination of a study, a report has to be submitted to the NHSRC using standard forms obtainable from the NHSRC Secretariat.
- **QUESTIONS**: Please contact the NHSRC on Telephone No. (01) 789314, 08588957 or by e-mail on doccentre@malawi.net
- **Other:**
  Please be reminded to send in copies of your final research results for our records as well as for the Health Research Database.

Kind regards from the NHSRC Secretariat.

.....
FOR CHAIRMAN, NATIONAL HEALTH SCIENCES RESEARCH COMMITTEE

PROMOTING THE ETHICAL CONDUCT OF RESEARCH
Executive Committee: *Dr.C.Mwansambo (Chairman), Prof. Mfutso Bengo (Vice Chairperson)*
Registered with the USA Office for Human Research Protections (OHRP) as an International IRB
(IRB Number IRB00003905 FWA00005976)